

***United States Court of Appeals
for the Second Circuit***



EXHIBITS

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ORIGINAL

In The
United States Court of Appeals
For The Second Circuit

UNITED STATES OF AMERICA,

Appellee,

-against-

ANTHONY NAPOLI,

Defendant-Appellant.

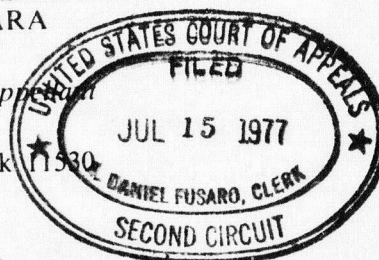
*On Appeal from a Judgment of Conviction of the United
District Court for the Southern District of New York.*

EXHIBIT VOLUME

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POLLIO & DUNNE, P.C.

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Garden City, New York 11530
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THE CITY OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES

EXHIBIT 1 - INVOICE FOR E1
DOCTOR'S SERVICES (ROSALINE)

INVOICE FOR DOCTOR'S SERVICES

CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napoli</i> 4/15/72 SIGNATURE OF DOCTOR DATE		INVOICE NO S896339		SHEET NUMBER 1 OF 1 SHEETS	
		DOCTOR'S IDENTIFICATION 2 NUMBER 3 6 0 0 0 1 5 1 5 3 TYPE OF PRACTICE (X) Chiropractic 4 NAME Anthony Napoli 5 STREET ADDRESS 166A Lee Ave. 6 POST OFFICE STATE ZIP CODE Brooklyn, N.Y. 11211 7 TELEPHONE NUMBER 596-1411			

PA-ADC		PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION										12 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)	
8 IDENTIFICATION NUMBER		9 IDENT NAME (LAST NAME ONLY)		10 M.A. OFFICE		11 OTHER							
3 0 2 4 1 8 5 1		Ere		066		3							
LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY				
13	14		15	16	17	18	19	20	ADJ. REI. CODE	ADJUSTED AMOUNT			
01	Rosaline	F	49	3/8/72	C-001		Migraine	3.00					
02	Rosaline	F	49	3/10/72	C-001		Migraine	3.00					
03	Rosaline	F	49	3/11/72	C-001		Migraine	3.00					
04	Rosaline	F	49	3/15/72	C-001		Migraine	3.00					
05	Rosaline	F	49	3/18/72	C-001		Migraine	3.00					
06	Rosaline	F	49	3/24/72	C-001		Migraine	3.00					
07	Rosaline	F	49	3/29/72	C-001		Migraine	3.00					
08	Rosaline	F	49	4/5/72	C-001		Migraine	3.00					
09	Rosaline	F	49	4/10/72	C-001		Migraine	3.00					
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20													

21 REFERRING DOCTOR, IF ANY.

TOTAL	37.00
AUDITED BY	DATE

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

SEE REVERSE SIDE OF THIS FORM FOR DETAILED INSTRUCTIONS

EXHIBIT 2 - INVOICE FOR DOCTOR'S SERVICES (NYDIA)
DEPARTMENT OF SOCIAL SERVICES (pp. E2-E3)

E2

INVOICE FOR DOCTOR'S SERVICES

23 CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napoli</i> 3/21/72 SIGNATURE OF DOCTOR DATE	INVOICE NO R649539		1 SHEET NUMBER 1 OF 1 SHEETS
	DOCTOR'S IDENTIFICATION		
	2 NUMBER 3 6 0 0 0 1 5 1 5	3 TYPE OF PRACTICE (X) Chiropractic	
	4 NAME Anthony Napoli		
5 STREET ADDRESS 365 A Lee Ave.		6 POST OFFICE STATE ZIP CODE Brooklyn, N.Y. 11211	7 TELEPHONE NUMBER 526-1411

PA-ADC				PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION			
8 IDENTIFICATION NUMBER	9 SUFF	10 IDENT NAME (LAST NAME ONLY)	11 MA OFFICE	12 OTHER	13 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)		
2 7 7 9 2 5 2	1	Barrientes	084	N			

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
									ADJ. REF. CODE	ADJUSTED AMOUNT
13	14		15	16	17	18	19	20		
01	Nydia	F	45	2/9/72	C-001		Migraine	3.00		
02	Nydia	F	45	2/11/72	C-001		Migraine	3.00		
03	Nydia	F	45	2/14/72	C-001		Migraine	3.00		
04	Nydia	F	45	2/16/72	C-001		Migraine	3.00		
05	Nydia	F	45	2/23/72	C-001		Migraine	3.00		
06	Nydia	F	45	2/26/72	C-001		Migraine	3.00		
07	Nydia	F	45	3/1/72	C-001		Migraine	3.00		
08	Nydia	F	45	3/6/72	C-001		Migraine	3.00		
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21 REFERRING DOCTOR, IF ANY

TOTAL	22	24.00	DATE
AUDITED BY			

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

SEE REVERSE SIDE OF THIS FORM FOR DETAILED INSTRUCTIONS

BEST COPY AVAILABLE

TREATMENT PLAN
CHIROPRACTIC DIVISION

INSTRUCTIONS: Submit this form in triplicate after the 3rd but prior to the 4th visit to: Director of Chiropractic, Bureau of Health Care Svcs., 330 West 34th St., N.Y.N.Y. 10001.

Two copies will be returned with Health Dept. decision. The original MUST BE ATTACHED to your Invoice for Doctor's Services (form W 303G) when claiming payment.

1 PATIENT'S LAST NAME		FIRST	
Barrientes		Nydia	
STREET ADDRESS			
746 Driggs Ave.			
POST OFFICE		STATE	
Brooklyn, N.Y.		11211	
TELEPHONE NO.		SEX	DATE OF BIRTH
		☐ M ☒ F	1945
IDENT NO.		SUFFIX	EXP. DATE ON CARD
2 7 7 9 2 5 2 1			2/28/72
2 NAME OF CHIROPRACTOR		3 NAME ON IDENT. CARD	
Anthony Vapoli		Barrientes	
STREET ADDRESS		SOCIAL SECURITY NO.	
166 A Lee Ave.			
CITY		ZIP CODE	
Brooklyn, N.Y.		11211 11211	
TELEPHONE NO.		4 CARE RENDERED AT	
AT 596-5411		☒ DOCTOR'S OFFICE ☐ PATIENT'S HOME	
CERTIFICATION NO.		☐ OTHER ADDRESS (Specify)	
3 6 0 0 1 5 1 5			

5 HISTORY CHIEF COMPLAINT, DURATION OF PRESENT ONSET

Frontal Head pain occurring 1 to 2 times per week when attacks come on they last anywhere from several hours to a whole day. And severe occasionally they cause nausea and vomiting. 11 1 year.

6 EXAMINATION, CLINICAL FINDINGS

① X-ray findings are essentially negative for osseous pathology with mild degree of arthritic changes.
② Eye fundus essentially negative for papilloedema or vascular changes.
③ Blood pressure 120/80. Compression test is negative.
④ Romberg test and sway test both positive - cerebellar involvement.

DIAGNOSIS

Migraine

7 CHIROPRACTIC ANALYSIS AND TREATMENT PLAN

① CR shows rotated posteriorly and superior. ② moderately diminished cervical lordosis. ③ marked tenderness and spasticity of paraspinal musculature - vertebral manipulation to release existing blockages and restore posture and improve blood flow supply to involved areas.

Complaint, known or suspected, not within legal limits of Chiropractic Care.

Currently under care by Physician or Clinic

(Enter Name and Address)

M.D.
Clinic

Being referred to

(Name and Address)

M.D. or

(Name and Address)

Clinic

DATE OF INITIAL VISIT	NUMBER VISITS COMPLETED	DATE OF LAST VISIT	ADDITIONAL VISITS REQUESTED
2/9/72	4	2/16/72	5
Signature of Chiropractor		Date	
Anthony Vapoli		2/21/72	

EXHIBIT 3 - INVOICE FOR DOCTOR'S SERVICES (BARBARA)
(pp. E4-E5)

E4

INVOICE FOR DOCTOR'S SERVICES

4 copies

CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napoli</i> <i>5/6/72</i> SIGNATURE OF DOCTOR DATE		INVOICE NO R649606		SHEET NUMBER 1 OF 1 SHEETS	
		DOCTOR'S IDENTIFICATION			
		1 NUMBER 360001515		3 TYPE OF PRACTICE (1) Chiropractic	
		4 NAME Anthony Napoli			
		5 STREET ADDRESS 166 Lee Ave.			
		6 POST OFFICE, STATE, ZIP CODE Brooklyn, N.Y. 11211		7 TELEPHONE NUMBER 596-1411	

PA-1 DC		PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION			
8 IDENTIFICATION NUMBER 13489911		9 IDENT NAME (LAST NAME ONLY) Tolliver		10 M.A. OFFICE 11 OTHER 063 N	
		12 SOCIAL SECURITY CLAIM NUMBER (MEDICAID ONLY)			

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
13	14		15	16	17	18	19	20	ADJ. / REJ. CODE	ADJUSTED AMOUNT
01	Barbara	F	32	3/10/72	C-001		Osteo Arthritis	3.00		
02	Barbara	F	32	3/11/72	C-001		Osteo Arthritis	3.00		
03	Barbara	F	32	3/13/72	C-001		Osteo Arthritis	3.00		
04	Barbara	F	32	3/17/72	C-001		Osteo Arthritis	3.00		
05	Barbara	F	32	3/20/72	C-001		Osteo Arthritis	3.00		
06	Barbara	F	32	3/24/72	C-001		Osteo Arthritis	3.00		
07	Barbara	F	32	3/31/72	C-001		Osteo Arthritis	3.00		
08	Barbara	F	32	4/3/72	C-001		Osteo Arthritis	3.00		
09	Barbara	F	32	4/8/72	C-001		Osteo Arthritis	3.00		
✓10	Barbara	F	32	4/12/72	C-001		Osteo Arthritis	3.00		
✓11	Barbara	F	32	4/15/72	C-001		Osteo Arthritis	3.00		
12	Barbara	F	32	4/17/72	C-001		Osteo Arthritis	3.00		
13										
14										
15										
16										
17										
18										
19										
20										

21 REFERRING DOCTOR, IF ANY:								TOTAL 36.00	
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PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

BEST COPY AVAILABLE

**TREATMENT PLAN
CHIROPRACTIC DIVISION**

INSTRUCTIONS: Submit this form in triplicate after the 3rd but prior to the 4th visit to: Director of Chiropractic, Bureau of Health Care Svces., 330 West 34th St., N.Y.N.Y. 10001.

Two copies will be returned with Health Dept. decision. The original **MUST BE ATTACHED** to your Invoice for Doctor's Services (form W 303G) when claiming payment.

4/17/72

1 PATIENT'S LAST NAME		FIRST	
Tolliver		Barbara	
STREET ADDRESS			
97 Rutledge St.			
POST OFFICE		STATE	ZIP CODE
Brooklyn, N.Y.		11211	
TELEPHONE NO.	SEX	DATE OF BIRTH	TYPE ASST. CODE
	☐ M ☒ F	1932	PA-ADC
IDENT NO		SUFFIX	EXP. DATE ON CARD
1	3 4 8 9 9 1	1	4/30/72

2 NAME OF CHIROPRACTOR		3 NAME ON IDENT. CARD	
Anthony Napoli		Tolliver	
STREET ADDRESS		SOCIAL SECURITY NO.	
166 A Lee Ave.			
CITY	STATE	ZIP CODE	4 CARE RENDERED AT
Brooklyn, N.Y.		11211	☒ DOCTOR'S OFFICE ☐ PATIENT'S HOME
TELEPHONE NO.	CERTIFICATION NO.	☐ OTHER ADDRESS (Specify)	
596-1411	3 0 0 0 1 5 1 5		

5 HISTORY CHIEF COMPLAINT, DURATION OF PRESENT ONSET

Patient complains of Low back pain. There is extreme pain in prolonged walking, sitting and standing, patient states "she feels back is going to split in two". Pain is also present in trunk flexion. Duration of Complaint is 1 year.

6 EXAMINATION, CLINICAL FINDINGS.

X-rays are essentially negative for any osseous pathology, however x-rays do show osteo-arthritic changes. Rotation test is positive on the left for lumbo-sacral involvement. Patrick Faber test is positive on the right for Lumbo-sacral lesion. Lasague Test is negative. Soto-Hall test is positive for lumbar involvement.

X-RAYS	DATE TAKEN	NO. OF FILMS
C 720		
C 721		
C 722		
C 723		

DIAGNOSIS Osteo-Arthritis

7 CHIROPRACTIC ANALYSIS AND TREATMENT PLAN

Right iliac crest inferior as is right sacral base which is also posterior. Increased antero-postero lumbar curve. Marked para-spinal tenderness pronounced over right ilio-sacral articulation. Vertebral manipulation to reduce subluxation, nerve pressure, spasm and improve lumbar mobility.

8 REFERABLE CLINICAL CONDITIONS

Complaint, known or suspected, not within legal limits of Chiropractic Care _____

Currently under care by Physician or Clinic _____ M.D. Clinic
(Enter Name and Address)

Being referred to _____ M.D. or _____ Clinic
(N. me and Address) (Name and Address)

9 DATE OF INITIAL VISIT	NUMBER VISITS COMPLETED	DATE OF LAST VISIT	ADDITIONAL VISITS REQUESTED
3/10/72	3	3/13/72	9
Signature of Chiropractor		Date	

DEPARTMENT OF SOCIAL SERVICES EXHIBIT 5 - INVOICE FOR
INVOICE FOR DOCTOR'S SERVICES DOCTOR'S SERVICES
(SARA)

E6

23 CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Lapoli</i> <i>1/23/72</i> SIGNATURE OF DOCTOR DATE	INVOICE NO S896390		SHEET NUMBER 1 OF 1 SHEETS	
	DOCTOR'S IDENTIFICATION			
	2 NUMBER 360001515		3 TYPE OF PRACTICE (2) Chiropractic	
	4 NAME Anthony Lapoli 5 STREET ADDRESS 166A Lee A. P. 6 POST OFFICE STATE, ZIP CODE Brooklyn, N.Y. 11211 7 TELEPHONE NUMBER 526-1411			

PA-MC PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION											
8 IDENTIFICATION NUMBER 3024091		9 IDENT NAME (LAST NAME ONLY) Diaz		10 M.A. OFFICE 066		11 OTHER N		12 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)			

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
13	14		15	16	17	18	19	20	ADJ / REJ CODE	ADJUSTED AMOUNT
01	Sara	F	49	4/3/72	C-001		Sciatica & L/S Strain	3.00		
02	Sara	F	49	4/5/72	C-001		Sciatica & L/S Strain	3.00		
03	Sara	F	49	4/10/72	C-001		Sciatica & L/S Strain	3.00		
04	Sara	F	49	4/15/72	C-001		Sciatica & L/S Strain	3.00		
05	Sara	F	49	4/22/72	C-001		Sciatica & L/S Strain	3.00		
06	Sara	F	49	4/29/72	C-001		Sciatica & L/S Strain	3.00		
07	Sara	F	49	5/3/72	C-001		Sciatica & L/S Strain	3.00		
08	Sara	F	49	5/6/72	C-001		Sciatica & L/S Strain	3.00		
09	Sara	F	49	5/10/72	C-001		Sciatica & L/S Strain	3.00		
10	Sara	F	49	5/13/72	C-001		Sciatica & L/S Strain	3.00		
11	Sara	F	49	5/17/72	C-001		Sciatica & L/S Strain	3.00		
12										
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19										
20										
21 REFERRING DOCTOR, IF ANY:								TOTAL		
								33.00		

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

22	AUDITED BY	DATE

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

SEE REVERSE SIDE OF THIS FORM FOR DETAILED INSTRUCTIONS

EXHIBIT 6 - INVOICE FOR DOCTOR'S SERVICES (DOROTHY)
THE CITY OF NEW YORK (PP. E7-E8)
DEPARTMENT OF SOCIAL SERVICES

E7

RECEIVED INVOICE FOR DOCTOR'S SERVICES

8/25/72

*72 JUN 22 AM 11:46

INVOICE NO R649691		SHEET NUMBER 1 OF 1 SHEETS	
DOCTOR'S IDENTIFICATION			
2 NUMBER 5 6 0 0 0 1 5 1 5		3 TYPE OF PRACTICE (X) Chiropractic	
4 NAME Anthony Napoli			
5 STREET ADDRESS 166A Lee Ave.			
6 POST OFFICE, STATE, ZIP CODE Brooklyn, N.Y. 11211		7 TELEPHONE NUMBER 596-1411	

CERTIFICATION

I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid.

Anthony Napoli 6/14/72
SIGNATURE OF DOCTOR DATE

PA-ADC

PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION

8 IDENTIFICATION NUMBER 2 0 1 3 5 1 5		9 IDENT NAME (LAST NAME ONLY) Lee		10 MA OFFICE 11 OTHER 063 H		12 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)	
---	--	---	--	---------------------------------------	--	---	--

LINE NUMBER		PATIENT'S NAME		SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
13		14			15	16	17	18	19	20	ADJ / REL CODE	ADJUSTED AMOUNT
01		Dorothy	F	32	5/10/72	C-001			L/S Strain	3.00		
02		Dorothy	F	32	5/12/72	C-001			L/S Strain	3.00		
03		Dorothy	F	32	5/15/72	C-001			L/S Strain	3.00		
04		Dorothy	F	32	5/19/72	C-001			L/S Strain	3.00		
05		Dorothy	F	32	5/22/72	C-001			L/S Strain	3.00		
06		Dorothy	F	32	5/26/72	C-001			L/S Strain	3.00		
07		Dorothy	F	32	6/2/72	C-001			L/S Strain	3.00		
08		Dorothy	F	32	6/5/72	C-001			L/S Strain	3.00		
09		Dorothy	F	32	6/9/72	C-001			L/S Strain	3.00		
00		Dorothy	F	32	6/14/72	C-001			L/S Strain	3.00		
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**TREATMENT PLAN
CHIROPRACTIC DIVISION**

INSTRUCTIONS: Submit this form in triplicate after the 3rd but prior to the 4th visit to: Director of Chiropractic, Bureau of Health Care Svcs., 330 West 34th St., N.Y.N.Y. 10001.

Two copies will be returned with Health Dept. decision. The original **MUST BE ATTACHED** to your Invoice for Doctor's Services (form W 303G) when claiming payment.

1 PATIENT'S LAST NAME		FIRST	
Dorothy			
STREET ADDRESS			
90 Penn St.			
STATE		ZIP CODE	
11211		11211	
TELEPHONE NO.		SEX	DATE OF BIRTH
		☐ M ☒ F	1932
IDENT. NO.		SUFFIX	TYPE ASST. CODE
2 0 1 3 5 1 5			PA-ADC
EXP. DATE ON CARD			
6/30/72			

2 NAME OF CHIROPRACTOR		3 NAME ON IDENT. CARD	
Anthony Napoli		Lee	
STREET ADDRESS		SOCIAL SECURITY NO.	
166A Lee Ave.			
CITY	STATE	ZIP CODE	4 CARE RENDERED AT
Brooklyn, N.Y.		11211	☒ DOCTOR'S OFFICE ☐ PATIENT'S HOME
TELEPHONE NO.	CERTIFICATION NO.	☐ OTHER ADDRESS (Specify)	
596-1411	3 6 0 0 0 1 5 1 5		

5 HISTORY CHIEF COMPLAINT, DURATION OF PRESENT ONSET

Patient complains of low back pain in flexion, walking with difficulty in arising out of chairs. She states often she has difficulty straightening when getting out of bed. Duration of complaint is 3 years.

Patient is very obese.

6 EXAMINATION, CLINICAL FINDINGS.

X-ray findings are essentially negative for any osseous pathology. Rotation test is positive bilaterally for lumbo sacral involvement. Lewin Lasague test is positive for lumbar involvement, as is the Lewin Suppina test. Soto Hall test is negative. Faber test is positive for left lumbar lesion. Ely test is positive for lumbar lesion bilaterally.

X-RAYS	DATE TAKEN	NO. OF FILMS
C 720		
C 721		
C 722		
C 723		

DIAGNOSIS **L/S Strain**

7 CHIROPRACTIC ANALYSIS AND TREATMENT PLAN

Right iliac crest is inferior. There is an increased antero postero lumbar curve. Right lumbar scoliosis. Marked para spinal tenderness and spasticity. Vertebral manipulation to reduce subluxation, nerve pressure and improve mobility of lumbar spine.

8 REFERABLE CLINICAL CONDITIONS

Complaint, known or suspected, not within legal limits of Chiropractic Care.

Currently under care by Physician or Clinic (Enter Name and Address) M.D. Clinic

Being referred to (Name and Address) M.D. or (Name and Address) Clinic

9 DATE OF INITIAL VISIT	NUMBER VISITS COMPLETED	DATE OF LAST VISIT	ADDITIONAL VISITS REQUESTED
5/10/72	3	5/15/72	7
Signature of Chiropractor			Date
Anthony Napoli			5/16/72
FOR HEALTH DEPARTMENT USE ONLY			

EXHIBIT 7 - INVOICE FOR DOCTOR'S SERVICES (LOUISE)

INVOICE FOR DOCTOR'S SERVICES

CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Lopez</i> 7/5/72 SIGNATURE OF DOCTOR DATE	INVOICE NO \$896440 DOCTOR'S IDENTIFICATION 1 NUMBER 3 6 0 0 0 2 5 7 5 (X) Chiropractic 2 NAME Anthony Lopez 3 STREET ADDRESS 166A Lee Ave. 4 POST OFFICE, STATE, ZIP CODE Brooklyn, N.Y. 11211 5 TELEPHONE NUMBER 596-1411
---	--

PA-ADC PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION

6 IDENTIFICATION NUMBER	7 SUFF	8 IDENT NAME (LAST NAME ONLY)	9 MA OFFICE	10 OTHER	12 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)
2 4 0 4 5 4 7	1	Cherry	064	X	

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
									ADJ. REF. CODE	ADJUSTED AMOUNT
13	14		15	16	17	18	19	20		
01	Louise	F	36	5/31/72	C-001		Ther. Myositis	3.00		
02	Louise	F	36	6/2/72	C-001		Ther. Myositis	3.00		
03	Louise	F	36	6/3/72	C-001		Ther. Myositis	3.00		
04	Louise	F	36	6/16/72	C-001		Ther. Myositis	3.00		
05	Louise	F	36	6/19/72	C-001		Ther. Myositis	3.00		
06	Louise	F	36	6/23/72	C-001		Ther. Myositis	3.00		
07	Louise	F	36	6/26/72	C-001		Ther. Myositis	3.00		
08	Louise	F	36	6/28/72	C-001		Ther. Myositis	3.00		
09	Louise	F	36	7/1/72	C-001		Ther. Myositis	3.00		
10	Louise	F	36	7/3/72	C-001		Ther. Myositis	3.00		
11										
12										
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15										
16										
17										
18										
19										
20										

21 REFERRING DOCTOR, IF ANY:	TOTAL 30.00	22 AUDITED BY DATE
--	---	---

PLEASE NOTE: Prepare this invoice in triplicate (one set)
 Print or type all entries
 Submit original and duplicate to:

EXHIBIT 8 - INVOICE FOR DOCTOR'S SERVICES (BERTHA)
THE CITY OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES

E10

INVOICE FOR DOCTOR'S SERVICES

CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Papoli</i> 7/1/72 SIGNATURE OF DOCTOR DATE		INVOICE NO. R549726		SHEET NUMBER 1 OF 1 SHEETS						
		DOCTOR'S IDENTIFICATION 1 NUMBER 3 0 0 0 1 5 1 5 2 TYPE OF PRACTICE (X) Chiropractic 3 NAME Anthony Papoli 4 STREET ADDRESS 166A Lee Ave. 5 POST OFFICE, STATE, ZIP CODE Brooklyn, N.Y. 11211 6 TELEPHONE NUMBER 596-1411								
PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION 7 IDENTIFICATION NUMBER 2 5 5 6 8 9 0 1 8 IDENT NAME (LAST NAME ONLY) C. M. S. H. A. 9 M.A. OFFICE 10 OTHER OC2 11 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)										
LINE NUMBER	PATIENT'S NAME	SEX	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT (MO/DAY/YEAR)	SERVICE CODE	NO. OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THREE COLUMNS FOR OPS USE ONLY	
13	14	15	16	17	18	19	20	21	22	23
01	Bertha	F	41	5/24/72	C-001	1/2	Strain - Myositis	3.00		
02	Bertha	F	41	5/25/72	C-001	1/2	Strain - Myositis	3.00		
03	Bertha	F	41	5/25/72	C-001	1/2	Strain - Myositis	3.00		
04	Bertha	F	41	6/9/72	C-001	1/2	Strain - Myositis	3.00		
05	Bertha	F	41	6/14/72	C-001	1/2	Strain - Myositis	3.00		
06	Bertha	F	41	6/16/72	C-001	1/2	Strain - Myositis	3.00		
07	Bertha	F	41	6/21/72	C-001	1/2	Strain - Myositis	3.00		
08	Bertha	F	41	6/23/72	C-001	1/2	Strain - Myositis	3.00		
09	Bertha	F	41	6/26/72	C-001	1/2	Strain - Myositis	3.00		
10	Bertha	F	41	6/30/72	C-001	1/2	Strain - Myositis	3.00		
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
TOTAL								30.00		

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

BEST COPY AVAILABLE

DEPARTMENT OF SOCIAL SERVICES
EXHIBIT 10 - INVOICE FOR DOCTOR'S
INVOICE FOR DOCTOR'S SERVICES SERVICES (LYNETTE)

23 CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Lapoli</i> 7/5/72 SIGNATURE OF DOCTOR DATE	INVOICE NO S896436 1 SHEET NUMBER 1 OF 1 SHEET DOCTOR'S IDENTIFICATION 2 NUMBER 3 6 6 0 6 1 5 1 5 3 TYPE OF PRACTICE (7) Chiropractic 4 NAME Anthony Lapoli 5 STREET ADDRESS 166A Len Ave. 6 POST OFFICE, STATE, ZIP CODE Brooklyn, N.Y. 11211 7 TELEPHONE NUMBER 696-1431
--	--

PA-ADC			PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION		
8 IDENTIFICATION NUMBER 1 9 5 0 1 4 7 1	9 SUFF 7 1	10 IDENT NAME (LAST NAME ONLY) Brown	11 MA OFFICE 062	12 OTHER N	13 SOCIAL SECURITY CLAIM NUMBER (MEDICARE OR MEDICAID)

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
									ADJ / REJ CODE	ADJUSTED AMOUNT
13	14		15	16	17	18	19	20		
01	Lynette	F	31	5/31/72	C-061		L/S Strain	3.00		
02	Lynette	F	31	6/2/72	C-061		L/S Strain	3.00		
03	Lynette	F	31	6/6/72	C-061		L/S Strain	3.00		
04	Lynette	F	31	5/16/72	C-061		L/S Strain	3.00		
05	Lynette	F	31	6/19/72	C-061		L/S Strain	3.00		
06	Lynette	F	31	6/23/72	C-061		L/S Strain	3.00		
07	Lynette	F	31	6/26/72	C-061		L/S Strain	3.00		
08	Lynette	F	31	6/23/72	C-061		L/S Strain	3.00		
09	Lynette	F	31	7/1/72	C-061		L/S Strain	3.00		
10	Lynette	F	31	7/3/72	C-061		L/S Strain	3.00		
11										
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18										
19										
20										

21 REFERRING DOCTOR, IF ANY:	TOTAL 36.00	22 AUDITED BY DATE
-------------------------------------	----------------------------------	----------------------------------

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

SEE REVERSE SIDE OF THIS FORM FOR DETAILED INSTRUCTIONS

EXHIBIT 10A - ST. JOHNS HOSPITAL RECORD (LYNETTE BROWN)

BROWN, LYNETTE (pp.E12-E14) 72-1-5542

317B MSP 55

111 NOSTRAND AVENUE BROOKLYN NY 11206

TEL NO 643-0523

REFERRED BY DR. ALIZABAH

DATE 11/2/72

TOP D AND C TUBAL LOCATION

PT. PREV. HOSP. ADM. NONE HERE

NAME OF HOSPITAL NONE

BIRTHPLACE CITY & STATE GEORGIA

HOW LONG IN NY

HOW LONG IN NY

72355

BLUE CROSS N.Y. MEDICARE

MEDICAID

SELFHOLDER

HOLDER'S NAME

BROWN LYNETTE

REL. TO PATIENT

EFF. DATE & SOURCE OF PAYMENT

UNION'S NAME AND LOCAL NO

T/A PA-ADC-

1950147 1 A1 A1 6/30/72 GEN

TEL NO

HOLDER'S SS NO

FATHER'S NAME

ULRICH TODD

PLACE OF BIRTH

GA/

MOTHER'S MAIDEN NAME

MORTEN

BUTTS

PLACE OF BIRTH

GA/

FINAL DIAGNOSES:

CODE NO

*uter pregnancy tube
muller's*

412.009

OPERATIONS

Top D-a

1 3rd Tub. hyster

412-114

282-11

CONDITION ON DISCHARGE:

REC.

IMP.

UNIMP.

TRANSF. TO OTHER INST.

DIED

AUTOPSY

FINAL SUMMARY

RECORD PERTINENT HISTORY & PHYSICAL FINDINGS

LAB DATA

XRAY FINDING

COURSE IN HOSP. INCLUDING THERAPY AND RESPONSE TO THERAPY

SIGNATURE OF HOUSE PHYSICIAN

SIGNATURE OF ATTENDING PHYSICIAN

BEST COPY AVAILABLE

E13

ST. JOHN'S EPISCOPAL HOSPITAL

480 HERKIMER STREET
BROOKLYN, N. Y. 11213

Discharge Summary

PATIENT: BROWN, LYNETTE
AGE: 28 SEX: Female

UNIT # 72355

HOSPITAL #: 72-5542

DATE OF ADMISSION: 6/4/72

DATE OF DISCHARGE: 6/9/72

CHIEF COMPLAINT: Pregnancy.

PRESENT ILLNESS: The patient is a 28 year old gravida 6, para 5, with the last normal menstrual period was 4/18/72 who was admitted for the termination of pregnancy, and bilateral tubal ligation.

PAST HISTORY: Not significant.

FAMILY HISTORY: Not contributory.

PHYSICAL EXAMINATION: The physical examination was systematically within normal limits. Pelvic examination revealed the uterus was six weeks gestational size.

LABORATORY DATA: Hemoglobin was 12.8, hematocrit was 35, RH-B-positive. Urine was negative.

HOSPITAL COURSE: The patient had dilatation and curettage and bilateral tubal ligation. The postoperative course was uneventful and the patient was discharged in satisfactory condition.

FINAL DIAGNOSIS: Pregnancy.

Dictated by: Dr. Allardet

Attending: _____

Date: 2/14/73

E14

ST. JOHN'S EPISCOPAL HOSPITAL
OPERATIVE REPORT

PATIENT BROWN, LYNETTE DATE 6-5-72
UNIT# 7:355 ROOM 317E
SURGEON DR. ALIZADEH RESIDENT DR. ILIESCU ASSISTANT _____
PRE-OPERATIVE DIAG: Uterine pregnancy; multiparity.
POST OPERATIVE DIAG: Same.
OPERATION(S): Dilatation and curettage for termination of pregnancy;
tubal ligation.

FINDINGS AND PROCEDURE:

Under general anesthesia the patient was prepared and draped in the lithotomy position. After the area was prepped with betadine a pelvic examination revealed the uterus was enlarged to about 6 weeks, multi-fibroids, abscess of the left labia.

A heavy speculum was inserted into the vagina and the anterior lip of the cervix was grasped with a tenaculum. The tip of the fundus measured at about 6 inches. With Hegar dilators the cervix was dilated to a #20 and with a medium sized sharp curette the endometrium was scraped. Conceptive tissue was removed. Endometrium found to be slightly irregular, enlarged.

The patient was redraped in prone position. A midline abdominal incision was made parallel to linea alba. The incision was continued downward through the fascia, muscle and peritoneum. After the abdomen was opened the uterus was found post-partum. Adnexa were negative. The mid-portion of the right fallopian tube was grasped with a Babcock, the portion was ligated with 0 chromic and dissected. The same procedure was performed for the left fallopian tube by placing a Babcock on the mid-portion of the left fallopian tube. The portion was ligated and dissected.

The abdomen was closed in three layers. Continuous sutures used to close the peritoneum. Interrupted sutures used to close the fascia. Silk was used to close the skin.

The patient tolerated the procedure well, she was transferred to the recovery room in satisfactory condition. Wound expectancy clean. Estimated blood loss about 100 cc.

A/ro

TRANSMITTED 6-1-72

BEST COPY AVAILABLE

EXHIBIT 12 - INVOICE FOR DOCTOR'S SERVICES (LILLIE)
(pp. E15-E16)

E15

INVOICE FOR DOCTOR'S SERVICES

23 CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napoli</i> <i>7/26/72</i> SIGNATURE OF DOCTOR DATE	INVOICE NO X837268		1 SHEET NUMBER 1 OF 1 SHEETS
	DOCTOR'S IDENTIFICATION		
	2 NUMBER 3 6 0 0 0 1 5 1 5	3 TYPE OF PRACTICE (X) Chiropractic	
	4 NAME Anthony Napoli 5 STREET ADDRESS 366A 1st Ave. 6 POST OFFICE STATE ZIP CODE Brooklyn N.Y. 11211 7 TELEPHONE NUMBER 596-1411		

PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION				
8 IDENTIFICATION NUMBER 2 6 7 1 2 5 7 1	9 IDENT NAME (LAST NAME ONLY) Smith	10 M.A. OFFICE 078	11 OTHER N	12 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
									ADJ / REJ CODE	ADJUSTED AMOUNT
13	14		15	16	17	18	19	20		
01	L4111a	F	49	6/14/72	C-001		L/S Strain	3.00		
02	L4111a	F	49	6/17/72	C-001		L/S Strain	3.00		
03	L4111a	F	49	6/19/72	C-001		L/S Strain	3.00		
04	L4111a,	F	49	7/3/72	C-001		L/S Strain	3.00		
05	L4111a	F	49	7/7/72	C-001		L/S Strain	3.00		
06	L4111a	F	49	7/8/72	C-001		L/S Strain	3.00		
07	L4111a	F	49	7/12/72	C-001		L/S Strain	3.00		
08	L4111a	F	49	7/15/72	C-001		L/S Strain	3.00		
09	L4111a	F	49	7/21/72	C-001		L/S Strain	3.00		
10	L4111a	F	49	7/24/72	C-001		L/S Strain	3.00		
11										
12										
13										
14										
15										
16										
17										
18										
19										
20								TOTAL		
21 REFERRING DOCTOR, IF ANY:										
								22	30.00	

PLEASE NOTE: Prepare this invoice in triplicate (one en)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
830 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

**TREATMENT PLAN
CHIROPRACTIC DIVISION**

INSTRUCTIONS: Submit this form in triplicate after the 3rd but prior to the 4th visit to: Director of Chiropractic, Bureau of Health Care Svces., 330 West 34th St., N.Y.N.Y. 10001.

Two copies will be returned with Health Dept. decision. The original **MUST BE ATTACHED** to your Invoice for Doctor's Services (form W 303G) when claiming payment.

1 INSTRUCTIONS: Submit this form in triplicate after the 3rd but prior to the 4th visit to: Director of Chiropractic, Bureau of Health Care Svces., 330 West 34th St., N.Y.N.Y. 10001. Two copies will be returned with Health Dept. decision. The original MUST BE ATTACHED to your Invoice for Doctor's Services (form W 303G) when claiming payment.		1 PATIENT'S LAST NAME FIRST											
		Smith, Lillie											
		STREET ADDRESS											
		450 Madison Ave.											
		POST OFFICE	STATE	ZIP									
Brooklyn, N.Y.		11207											
TELEPHONE NO.	SEX	DATE OF BIRTH	TY										
	☐ M ☐ F	10/10											
IDENT NO	SUFFIX	EXP. DATE ON CARD											
2 C 7 1 2 5 7 1		8/22/72											
2 NAME OF CHIROPRACTOR		3 NAME ON IDENT. CARD											
Anthony Lepoli		Smith											
STREET ADDRESS		SOCIAL SECURITY NO.											
1801 Lee Ave.													
CITY	STATE	ZIP CODE	4 CARE RENDERED AT										
Brooklyn, N.Y.		11211	☒ DOCTOR'S OFFICE ☐ PATIENT'S HOME										
TELEPHONE NO.	CERTIFICATION NO.	☐ OTHER ADDRESS (Specify)											
586-1411	8 0 0 0 0 1 5 1 8												
5 HISTORY CHIEF COMPLAINT, DURATION OF PRESENT ONSET													
Low back pain in prolonged walking and standing and carrying of packages. Patient states in bending forward she finds it painful becoming erect. Pain is described as a dull dragging sensation and has been present since gestation 4 years ago.													
6 EXAMINATION, CLINICAL FINDINGS.													
Lumbar rotation test is positive bi-laterally. Gillis test is negative. Ely test is positive bi-laterally for lumbar lesion. Lasegue test is positive on the right for lumbar involvement. Lowin-Lasegue test is positive for lumbar involvement, as is Lowin-Supine Test. Soto Hall test is negative.													
DIAGNOSIS L/C Strain			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>X-RAYS</th> <th>DATE TAKEN</th> </tr> <tr> <td>C 720</td> <td></td> </tr> <tr> <td>C 721</td> <td></td> </tr> <tr> <td>C 722</td> <td></td> </tr> <tr> <td>C 723</td> <td></td> </tr> </table>	X-RAYS	DATE TAKEN	C 720		C 721		C 722		C 723	
X-RAYS	DATE TAKEN												
C 720													
C 721													
C 722													
C 723													
7 CHIROPRACTIC ANALYSIS AND TREATMENT PLAN													
Objective findings reveal a right iliac crest inferior. A right sacral base inferior and posterior. A diminished antero-postero lumbar curve with spasm and tenderness para-spinal. Vertebral manipulation to reduce nerve pressure, subluxation, spasticity and improve stability and motility of lumbar spine.													
8 REFERABLE CLINICAL CONDITIONS													
Complaint, known or suspected, not within legal limits of Chiropractic Care _____ Currently under care by Physician or Clinic _____ M.D. Clinic (Enter Name and Address) Being referred to _____ M.D. or _____ (Name and Address) (Name and Address)													
DATE OF INITIAL VISIT	NUMBER VISITS COMPLETED	DATE OF LAST VISIT	ADDITIONAL VISITS REQUESTED										
8/1/72	5	8/15/72	7										
Signature of Chiropractor			Date										
Anthony Lepoli			8/22/72										
FOR HEALTH DEPARTMENT USE ONLY													

DEPARTMENT OF SOCIAL SERVICES
EXHIBIT 13- INVOICE FOR DOCTOR'S SERVICES (ANGELICA)
 (pp. E17-E18) **INVOICE FOR DOCTOR'S SERVICES**

E17

CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napoli</i> 7/12/72 SIGNATURE OF DOCTOR DATE	DOCTOR'S IDENTIFICATION INVOICE NO. X837357 SHEET NUMBER <u>1</u> OF <u>1</u> SHEETS 2 NUMBER 3 6 0 0 0 1 5 1 5 3 TYPE OF PRACTICE (X) Chiropractic 4 NAME Anthony Napoli 5 STREET ADDRESS 166A Lee Ave. 6 POST OFFICE, STATE, ZIP CODE Brooklyn, N.Y. 11211 7 TELEPHONE NUMBER 595-1411
--	--

PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION			
8 IDENTIFICATION NUMBER 2 8 0 8 8 5 7 1	9 IDENT NAME (LAST NAME ONLY) Gonzalez	10 M.A. OFFICE 062	11 OTHER N

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
									ADJ. RES. CODE	ADJUSTED AMOUNT
13	14		15	16	17	18	19	20		
01	Angelica	F	48	6/30/72	C-001		Migraine	3.00		
02	Angelica	F	48	7/3/72	C-001		Migraine	3.00		
03	Angelica	F	48	7/5/72	C-001		Migraine	3.00		
04	Angelica	F	48	7/15/72	C-001		Migraine	3.00		
05	Angelica	F	48	7/19/72	C-001		Migraine	3.00		
06	Angelica	F	48	7/21/72	C-001		Migraine	3.00		
07	Angelica	F	48	7/24/72	C-001		Migraine	3.00		
08	Angelica	F	48	7/25/72	C-001		Migraine	3.00		
09	Angelica	F	48	7/31/72	C-001		Migraine	3.00		
10	Angelica	F	48	8/4/72	C-001		Migraine	3.00		
11										
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15										
16										
17										
18										
19										
20										

21 REFERRING DOCTOR, IF ANY:	TOTAL	30.00
PLEASE NOTE: Prepare this invoice in triplicate (one set) Print or type all entries Submit original and duplicate to:	AUDITED BY _____ DATE _____	

DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF MEDICAL PAYMENTS
 330 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

SEE REVERSE SIDE OF THIS FORM FOR DETAILED INSTRUCTIONS

TREATMENT PLAN
CHIROPRACTIC DIVISION *pt* E18

PATIENT'S LAST NAME FIRST
STREET ADDRESS
POST OFFICE STATE ZIP CODE
SEX ☐ M ☒ F DATE OF BIRTH 1948 TYPE ASST. CO. PA-ADO
IDENT. NO. SUFFIX 1 EXP. DATE ON CARD 6/30/72

INSTRUCTIONS: Submit this form in triplicate after the 3rd but prior to the 4th visit to: Director of Chiropractic, Bureau of Health Care Svcs., 330 West 34th St., N.Y.N.Y. 10001.

Two copies will be returned to Health Dept. decision. The original MUST BE ATTACHED to your Invoice for Doctor's Services (form W 303G) when claiming payment.

2 NAME OF CHIROPRACTOR *Anthony Lepore*
STREET ADDRESS *1001 Ave. C*
CITY *Brooklyn, N.Y.* STATE *N.Y.* ZIP CODE *11211*
TELEPHONE NO. *580-1411* CERTIFICATION NO. *810010011111*
3 NAME ON IDENT. CARD *Anthony Lepore*
SOCIAL SECURITY NO. *111111111*
4 CARE RENDERED AT ☒ DOCTOR'S OFFICE ☐ PATIENT'S HOME ☐ OTHER ADDRESS (Specify)

5 HISTORY CHIEF COMPLAINT, DURATION OF PRESENT ONSET
Frontal head pain and bi-temporally. Pain is severe and lasting 2 to 3 days. occurring 1 to 2 times per week, with dizziness, spotty vision, nausea leaving her tired afterwards. Duration of Complaint is 6 months.

6 EXAMINATION, CLINICAL FINDINGS.
Cervical compression testis positive for foraminal encroachment. Cervical cough test is negative. Spots Hall test is positive for cervical lesion. Romberg test is negative. Eye fundis is essentially negative for pathology. Adson's test negative. Blood pressure 120/70.

X RAYS	DATE TAKEN	NO. OF FILMS
C 720		
C 721		
C 722		
C 723		

7 CHIROPRACTIC ANALYSIS AND TREATMENT PLAN
Objective findings reveal an Atlas rotated posteriorly and inferiorly on the right. A right cervical scoliosis. Increased cervical lordosis. Range of motion limited on right cervical rotation. Marked para-spinal tenderness & spasm pronounced over the right Atlas & Axis. Vertebral manipulation to reduce nerve pressure, subluxation & fixation so that cervical spine is in a compensating state.

8 REFERABLE CLINICAL CONDITIONS
Complaint, known or suspected, not within legal limits of Chiropractic Care.
Currently under care by Physician or Clinic (Enter Name and Address) M.D. Clinic
Being referred to (Name and Address) M.D. or (Name and Address) Clinic

9 DATE OF INITIAL VISIT *6/30/72* NUMBER VISITS COMPLETED *3* DATE OF LAST VISIT *7/5/72* ADDITIONAL VISITS REQUESTED *7*

Signature of Chiropractor *Anthony Lepore* Date *7/5/72*

FOR HEALTH DEPARTMENT USE ONLY
☒ Number Visits Approved *7* *Sever* *Director of Chiropractic* *7/20/72*
☐ Disapproved

EXHIBIT 14- INVOICE FOR DOCTOR'S SERVICES (RAMONA)

E19

THE CITY OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES

INVOICE FOR DOCTOR'S SERVICES

CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <u>Anthony Napoli</u> <u>8/1/72</u> SIGNATURE OF DOCTOR DATE		INVOICE NO X837341		1 SHEET NUMBER <u>1</u> OF <u>1</u> SHEETS						
		2 NUMBER <u>3 6 0 0 0 1 5 1 5</u>		3 TYPE OF PRACTICE <u>(X) Chiropractic</u>						
4 NAME <u>Anthony Napoli</u>		5 STREET ADDRESS <u>1661 Lee Ave.</u>		7 TELEPHONE NUMBER <u>595-1411</u>						
6 POST OFFICE STATE ZIP CODE <u>Brooklyn N.Y. 11211</u>										
PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION										
8 IDENTIFICATION NUMBER <u>B-17C</u>		9 IDENT NAME (LAST NAME ONLY) <u>Solar</u>		10 MA OFFICE 11 OTHER <u>066 N</u>						
11 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)										
LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
13	14		15	16	17	18	19	20	ADJ / REJ CODE	ADJUSTED AMOUNT
01	Ramona	F	49	6/21/72	C-001		L/S Strain	3.00		
02	Ramona	F	49	6/23/72	C-001		L/S Strain	3.00		
03	Ramona	F	49	6/26/72	C-001		L/S Strain	3.00		
04	Ramona	F	49	7/8/72	C-001		L/S Strain	3.00		
05	Ramona	F	49	7/14/72	C-001		L/S Strain	3.00		
06	Ramona	F	49	7/17/72	C-001		L/S Strain	3.00		
07	Ramona	F	49	7/21/72	C-001		L/S Strain	3.00		
08	Ramona	F	49	7/24/72	C-001		L/S Strain	3.00		
09	Ramona	F	49	7/28/72	C-001		L/S Strain	3.00		
10	Ramona	F	49	7/31/72	C-001		L/S Strain	3.00		
11										
12										
13										
14										
15										
16										
17										
18										
19										
20	TOTAL							30.00		

21 REFERRING DOCTOR, IF ANY.

22 AUDITED BY

DATE

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
130 WEST 34TH ST NEW YORK, N. Y. 10001

EXHIBIT 15 - INVOICE FOR DOCTOR'S SERVICES (REGINA)

E 20

FORM W 363G
REV. 9/15/69
5000M-924048 (70)

THE CITY OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES

(pp. E20-E21)

INVOICE FOR DOCTOR'S SERVICES

23 CERTIFICATION		INVOICE NO X837353		SHEET NUMBER 1 OF 1 SHEETS	
I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napoli</i> <i>8/16/72</i> SIGNATURE OF DOCTOR DATE		DOCTOR'S IDENTIFICATION			
		2 NUMBER 3 6 0 0 0 1 5 1 5		3 TYPE OF PRACTICE (X) Chiropractic	
		4 NAME Anthony Napoli			
		5 STREET ADDRESS 1661 Lee Ave.			
		6 POST OFFICE STATE ZIP CODE Brooklyn, N.Y. 11211		7 TELEPHONE NUMBER 596-1411	

ADC		PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION	
1 IDENTIFICATION NUMBER 2 6 5 7 5 3 3 2	SUFF Smith	10 M.A. OFFICE 064	11 OTHER N

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DA/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
									ADJ REJ CODE	ADJUSTED AMOUNT
13	14		15	16	17	18	19	20		
01	Regina	F	51	6/23/72	C-001		Frontal Encephalgia	3.00		
02	Regina	F	51	6/28/72	C-001		Frontal Encephalgia	3.00		
03	Regina	F	51	7/1/72	C-001		Frontal Encephalgia	3.00		
04	Regina	F	51	7/15/72	C-001		Frontal Encephalgia	3.00		
05	Regina	F	51	7/19/72	C-001		Frontal Encephalgia	3.00		
06	Regina	F	51	7/22/72	C-001		Frontal Encephalgia	3.00		
07	Regina	F	51	7/26/72	C-001		Frontal Encephalgia	3.00		
08	Regina	F	51	7/29/72	C-001		Frontal Encephalgia	3.00		
09	Regina	F	51	8/2/72	C-001		Frontal Encephalgia	3.00		
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										

21 REFERRING DOCTOR, IF ANY

TOTAL

27.00

22 AUDITED BY

DATE

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

TREATMENT PLAN
CHIROPRACTIC DIVISION

INSTRUCTIONS: Submit this form in triplicate after the 3rd but prior to the 4th visit to: Director of Chiropractic, Bureau of Health Care Svcs., 330 West 34th St., N.Y.N.Y. 10001.

Two copies will be returned with Health Dept. decision. The original MUST BE ATTACHED to your Invoice for Doctor's Services (form W 303G) when claiming payment.

1 PATIENT'S LAST NAME		FIRST	
Smith		Regina	
STREET ADDRESS			
23 Westrand Ave.			
POST OFFICE		STATE	
Brooklyn, N.Y.		11206	
TELEPHONE NO.		SEX	DATE OF BIRTH
		☐ M ☒ F	1951
IDENT. NO.		SUFFIX	EXP. DATE ON CARD
1 6 5 7 5 3 3		2	8/31/72

2 NAME OF CHIROPRACTOR		3 NAME ON IDENT. CARD	
Anthony Napoli		Smith	
STREET ADDRESS		SOCIAL SECURITY NO.	
166A Lee Ave.			
CITY	STATE	ZIP CODE	4 CARE RENDERED AT
Brooklyn, N.Y.		11211	☒ DOCTOR'S OFFICE ☐ PATIENT'S HOME
TELEPHONE NO.	CERTIFICATION NO.		☐ OTHER ADDRESS (Specify)
596-1411	3 6 0 0 0 1 5 1 5		

5 HISTORY CHIEF COMPLAINT, DURATION OF PRESENT ONSET

Patient complains of bi-temporal and frontal head pain. Severe in nature and occurring at least 1 time per week, sometimes lasting all day. Duration of complaint is 6 months.

6 EXAMINATION, CLINICAL FINDINGS

Cervical compression test is negative. Cervical cough test is negative. Soto Hall test is positive for cervical lesion. Rhomberg & Finger to Nose tests negative. Eye Fundi essentially negative for pathology. Adson's test negative. Blood pressure 120/80. Soto Hall test positive for cervical lesion.

X RAYS	DATE TAKEN
C 720	
C 721	
C 722	
C 723	

DIAGNOSIS Frontal Encephalgia

7 CHIROPRACTIC ANALYSIS AND TREATMENT PLAN

Objective findings reveal Atlas and Axis rotated posteriorly & inferiorly on right. Left cervical scoliosis. Range of motion limited in right rotation. Marked spasm and tenderness para-spinally pronounced over Right Splenius Capitus. Vertebral manipulation to reduce subluxation, nerve pressure, spasm and improve cervical mobility.

8 REFERABLE CLINICAL CONDITIONS

Complaint, known or suspected, not within legal limits of Chiropractic Care

Currently under care by Physician or Clinic (Enter Name and Address)

M.D.
Clinic

Being referred to (Name and Address) M.D. or (Name and Address)

DATE OF INITIAL VISIT	NUMBER VISITS COMPLETED	DATE OF LAST VISIT	ADDITIONAL VISITS REQUESTED
6/23/72	3	7/1/72	6

Signature of Chiropractor *Anthony Napoli* Date 7/3/72

FOR HEALTH DEPARTMENT USE ONLY

DEPARTMENT OF SOCIAL SERVICES

EXHIBIT 16 - INVOICE FOR

F22

INVOICE FOR DOCTOR'S SERVICES

DOCTOR'S SERVICES
(ENEIDA)

CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napolitano</i> 9/1/72 SIGNATURE OF DOCTOR DATE		INVOICE NO X837445		SHEET NUMBER 1 OF 1 SHEETS	
		DOCTOR'S IDENTIFICATION			
		2 NUMBER 360001515		3 TYPE OF PRACTICE (X) Chiropractic	
		4 NAME Anthony Napolitano			
		5 STREET ADDRESS 166 Lee Ave.			
		6 POST OFFICE, STATE, ZIP CODE Brooklyn, N.Y. 11211		7 TELEPHONE NUMBER 596-1411	

P.A.M.C. PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION										
8 IDENTIFICATION NUMBER 29624661		9 IDENT NAME (LAST NAME ONLY) Rivera		10 M.A. OFFICE 063		11 OTHER N		12 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)		
LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	ADJ. REF. CODE	ADJUSTED AMOUNT
13	14		15	16	17	18	19	20		
01	Enaida	F	51	7/22/72	C-001		Migraine	3.00		
02	Enaida	F	51	7/26/72	C-001		Migraine	3.00		
03	Enaida	F	51	7/28/72	C-001		Migraine	3.00		
04	Enaida	F	51	8/1/72	C-001		Migraine	3.00		
05	Enaida	F	51	8/9/72	C-001		Migraine	3.00		
06	Enaida	F	51	8/12/72	C-001		Migraine	3.00		
07	Enaida	F	51	8/14/72	C-001		Migraine	3.00		
08	Enaida	F	51	8/18/72	C-001		Migraine	3.00		
09	Enaida	F	51	8/21/72	C-001		Migraine	3.00		
10	Enaida	F	51	8/25/72	C-001		Migraine	3.00		
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										

21 REFERRING DOCTOR, IF ANY:

TOTAL

30.00

AUDITED BY

DATE

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

SEE REVERSE SIDE OF THIS FORM FOR DETAILED INSTRUCTIONS

EXHIBIT 18 - INVOICE FOR DOCTOR'S SERVICES (JENNIE)

E23

FORM W-1099
REV. 9/1/72
80004-100-61 (72)THE CITY OF NEW YORK
HUMAN RESOURCES ADMINISTRATION
DEPARTMENT OF SOCIAL SERVICES

INVOICE FOR DOCTOR'S SERVICES

23		CERTIFICATION		INVOICE NO. 478125		1 SHEET NUMBER 1 OF 1 SHEETS	
I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napoli</i> 9/26/72 SIGNATURE OF DOCTOR DATE				DOCTOR'S IDENTIFICATION			
				2 NUMBER 360001515		3 TYPE OF PRACTICE (X) Chiropractic	
				4 NAME Anthony Napoli			
				5 STREET ADDRESS 166A Lee Av.			
				6 POST OFFICE, STATE, ZIP CODE Brooklyn, N.Y. 11211		7 TELEPHONE NUMBER 596-1411	

PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION									
PA-ADC									
8 IDENTIFICATION NUMBER 20339261									
9 IDENT. NAME (LAST NAME ONLY) Gonzalez									
10 M.A. OFFICE 068									
11 OTHER N									
12 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)									
LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO. OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY
13	14		15	16	17	18	19	20	ADJ. / REV. CODE
									ADJUSTED AMOUNT
01	Jennie	F	49	8/11/72	C-001		Cerv. Cran. Synd.	3.00	
02	Jennie	F	49	8/16/72	C-001		Cerv. Cran. Synd.	3.00	
03	Jennie	F	49	8/29/72	C-001		Cerv. Cran. Synd.	3.00	
04	Jennie	F	49	8/21/72	C-001		Cerv. Cran. Synd.	3.00	
05	Jennie	F	49	8/23/72	C-001		Cerv. Cran. Synd.	3.00	
06	Jennie	F	49	8/26/72	C-001		Cerv. Cran. Synd.	3.00	
07	Jennie	F	49	8/30/72	C-001		Cerv. Cran. Synd.	3.00	
08	Jennie	F	49	9/2/72	C-001		Cerv. Cran. Synd.	3.00	
09	Jennie	F	49	9/8/72	C-001		Cerv. Cran. Synd.	3.00	
10	Jennie	F	49	9/11/72	C-001		Cerv. Cran. Synd.	3.00	
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21 REFERRING DOCTOR, IF ANY:								TOTAL	
								22	30.00
								AUDITED BY	DATE

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

THE CITY OF NEW YORK
HUMAN RESOURCES ADMINISTRATION
DEPARTMENT OF SOCIAL SERVICES

EXHIBIT 19 - INVOICE FOR E24
DOCTOR'S SERVICES
(MARGARET)

INVOICE FOR DOCTOR'S SERVICES

23 CERTIFICATION I hereby certify that the services charged for below were furnished by me to the recipient(s) listed and that no part of this invoice has been previously paid. <i>Anthony Napoli</i> 9/2/72 SIGNATURE OF DOCTOR DATE	INVOICE NO. A 478151	1 SHEET NUMBER 1 OF 1 SHEETS	
	DOCTOR'S IDENTIFICATION		
	2 NUMBER 3 6 0 0 0 1 5 1 5	3 TYPE OF PRACTICE (X) Chiropractic	
	4 NAME Anthony Napoli		
	5 STREET ADDRESS 166 A Lee Ave.		
6 POST OFFICE, STATE, ZIP CODE Bklyn. N.Y. 11211		7 TELEPHONE NUMBER 596-1411	

PATIENT'S MEDICAL ASSISTANCE (MEDICAID) IDENTIFICATION

8 IDENTIFICATION NUMBER 2 3 7 5 8 9 1 1	9 IDENT. NAME (LAST NAME ONLY) Jackson	10 M.A. OFFICE 063	11 OTHER N	12 SOCIAL SECURITY CLAIM NUMBER (MEDICARE ONLY)
---	--	------------------------------	----------------------	---

LINE NUMBER	PATIENT'S NAME	SEX M OR F	YEAR OF BIRTH (LAST 2 DIGITS)	DATE OF VISIT MO/DAY/YEAR	SERVICE CODE	NO. OF UNITS	DIAGNOSIS	AMOUNT CLAIMED	THESE COLUMNS FOR DSS USE ONLY	
13	14		15	16	17	18	19	20	ADJ. / REJ. CODE	ADJUSTED AMOUNT
01	Margaret	F	42	8/9/72	C-001		Migraine	3.00		
02	Margaret	F	42	8/12/72	C-001		Migraine	3.00		
03	Margaret	F	42	8/14/72	C-001		Migraine	3.00		
04	Margaret	F	42	8/18/72	C-001		Migraine	3.00		
05	Margaret	F	42	8/21/72	C-001		Migraine	3.00		
06	Margaret	F	42	8/23/72	C-001		Migraine	3.00		
07	Margaret	F	42	8/26/72	C-001		Migraine	3.00		
08	Margaret	F	42	8/28/72	C-001		Migraine	3.00		
09	Margaret	F	42	9/2/72	C-001		Migraine	3.00		
10	Margaret	F	42	9/6/72	C-001		Migraine	3.00		
11	Margaret	F	42	9/9/72	C-001		Migraine	3.00		
12										
13										
14										
15										
16										
17										
18										
19										
20										
21 REFERRING DOCTOR, IF ANY:								TOTAL	22	
								33 00		

PLEASE NOTE: Prepare this invoice in triplicate (one set)
Print or type all entries
Submit original and duplicate to:

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL PAYMENTS
330 WEST 34TH ST. NEW YORK, N. Y. 10001

Retain triplicate for your record

SEE REVERSE SIDE OF THIS FORM FOR DETAILED INSTRUCTIONS

EXHIBIT 21 - STIPULATION

E25

UNITED STATES DISTRICT COURT (pp. E25-E28)
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,

- v -

ANTHONY NAPOLI,

Defendant.

STIPULATION

77 Cr. 167 (LFM)

IT IS HEREBY STIPULATED AND AGREED by and between counsel for the United States of America, and for the defendant, with the express consent of the defendant, that:

1. On July 30, 1965, Title XIX of the Social Security Act (the "Medicaid Act") was enacted creating the Medicaid program.
2. Pursuant to the Medicaid Act, the United States Department of Health, Education and Welfare shares with each state the cost of medical services to families with dependent children and to aged, blind, or permanently and totally disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services.
3. The Medicaid program further provides for rehabilitative and other services to help such families and individuals attain or retain capability for independence and self-care.
4. Pursuant to the Medicaid Act each state must promulgate a plan for Medical assistance.
5. On May 1, 1966 the State of New York enacted a statewide medical plan in accordance with the provisions of the Medicaid Act. The plan follows guidelines set by the Medicaid Act and Regulations and sets forth, in detail the requirements and standards by which federally-eligible funds for medicaid must be administered. Each welfare district must administer its program and submit its claims for

federal medicaid funds in accordance with this plan.

6. The New York State Social Welfare Law vests responsibility for the medical assistance program within New York State in the State Department of Social Services.

7. The City of New York is one of the 56 welfare districts in the state of New York. The Department of Social Services of the City of New York, located at 330 West 34th Street in Manhattan, which administers the Medicaid Program for the City of New York, processes and pays claims by various providers for Medicaid services rendered within New York City. The nature and amount of all such claims is reported monthly by New York City to the New York State Department of Social Services. Each monthly report (RF-2 and supporting Schedule E) contains a certification that the money expended for medical assistance was properly expended.

8. The New York State Department of Social Services submits quarterly to the Department of Health, Education and Welfare in Washington, D.C., a report (Form OA-41) detailing the nature and amount of such claims. Each report contains a certification from the state that the amounts claimed for federally-participating medicaid services were properly expended. A copy of the quarterly report is submitted to the Regional Office of the United States Department of Health, Education and Welfare located at 26 Federal Plaza, New York, New York.

9. The Department of Health, Education and Welfare reimburses federally-qualified claims at the rate of fifty cents on each dollar paid by the State of New York.

10. Anthony Napoli, the defendant, is licensed by the State of New York as a chiropractor and certified by the City of New York as a medicaid provider. His Medicaid provider number is 36-0001515. Chiropractic treatment is reimbursible under the Medicaid program.

11. At all times material herein Anthony Napoli, the defendant, practiced among other places at the Galler Medical Center, 858 Flushing Ave., Brooklyn, N.Y. and the Lee Avenue Medical Center at 166A Lee Ave., Brooklyn, N.Y. The business of said clinics is to provide Health-care services to Medicaid-eligible patients.

12. On or about the dates set forth below Anthony Napoli, the defendant, prepared, certified, and submitted as a claim for payment, Invoices for Doctor Services ("Invoice") to the New York City Department of Social Services:

<u>GX</u>	<u>DATE CERTIFIED</u>	<u>PATIENT'S NAME</u>	<u>INVOICE NUMBER</u>	<u>COUNT</u>
1	4/10/72	Rosaline Ero	S896339	1 and 21
2	3/21/72	Nydia Barrentes	R649539	2 and 22
3	5/2/72	Barbara Tolliver	R649606	3 and 23
4	5/2/72	Garrie Graham	R649747	4 and 24
5	5/23/72	Sara Diaz	S896390	5 and 25
6	6/14/72	Dorothy Lee	R649691	6 and 26
7	7/5/72	Louise Cherry	S896440	7 and 27
8	7/5/72	Bertha Cunningham	R649726	8 and 28
9	7/5/72	Milagros Lugo	R649714	9 and 29
10	7/5/72	Lynette Brown	S896436	10 and 30
11	7/26/72	Shirley Anne Crawford	X837294	11 and 31
12	7/26/72	Lillie Smith	X837268	12 and 32
13	8/16/72	Angelica Gonzalez	X837357	13 and 33
14	8/16/72	Ramona Soler	X837341	14 and 34
15	8/16/72	Regina Smith	X837359	15 and 35
16	9/6/72	Eneida Rivera	X837445	16 and 36
17	9/26/72	Ruth Barnes	A478122	17 and 37
18	9/26/72	Jennie Gonzalez	A478125	18 and 38
19	9/26/72	Margaret Jackson	A478151	19 and 39

13. Each patient named in GX 1 through 20 was eligible for federal Medicaid assistance during the time covered in her Invoice.

14. Each of the Invoices set forth in paragraph 12 was paid by the City of New York and Anthony Napoli, the defendant, received the proceeds.

15. The amounts paid on Invoices set forth in paragraph 12 were included in monthly RF-2's submitted by the City of New York to the New York State Department of Social Services.

16. The amounts set forth in the RF-2's were included in the quarterly OA-41's which were submitted by the State of New York to the United States Department of Health, Education and Welfare.

17. The federal government reimbursed the State of New York fifty cents on each dollar of claims submitted by New York State which included the amounts claimed in GX 1-20.

Dated: New York, New York

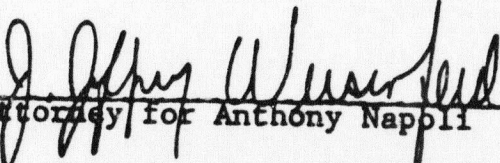
May , 1977

SO STIPULATED:

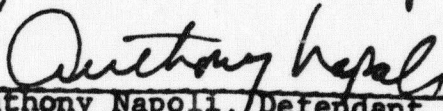
ROBERT B. FISKE, JR.
United States Attorney for the
Southern District of New York
Attorney for the United States
of America

By: _____

Assistant United States Attorney



Attorney for Anthony Napoli



Anthony Napoli, Defendant

IT-2102.1

Information Return for Recipients of
Medical and Health Care Payments—
1971 1972N. Y. STATE
INFORMATION
RETURN

Total medical and health care payments

\$27,457.20

Recipient's tax identifying number →

16 - 0001512

NAPOLI, ANTHONY
6404-13TH AVE.
BROOKLYN, N.Y. 1123413 - 6400434
DEPT. OF SOC. SERVICES
CITY OF NEW YORK
250 CHURCH ST.
NEW YORK, N.Y. 10013

PAID TO

PAID BY

BEST COPY AVAILABLE

EXHIBIT 27 - 1972 INCOME TAX RETURN
(pp. E30-E35)

United States



of Am

USA 336 - 475
(ED. 4-23-71)

E30

GOVERNMENT'S
EXHIBIT
U. S. DIST. COURT
S. D. OF N. Y.

TREASURY DEPARTMENT
INTERNAL REVENUE SERVICE

27 *at*

D

FPI MI-9-24-75 50M-4417

TO WHOM THESE PRESENTS SHALL COME, GREETING:

I certify that the annexed is a true copy of the original income tax return of Dr. Anthony Napoli, 1235 37th Street, Brooklyn, N.Y. for the year 1972. This return was filed in the Brooklyn District and is in my custody

under the custody of this office

IN WITNESS WHEREOF, I have hereunto set my hand, and caused the seal of this office to be affixed, on the day and year first above written.

By direction of the Secretary of the Treasury:

Charles H. Brennan
District Director
Internal Revenue Service
Manhattan District

FORM 2866 (REV 10-74)

Address (and ZIP Code) Proprietor's Emp. (Ident. of Soc. Sec. No.)

US Department of the Treasury / Internal Revenue Service

Individual Income Tax Return

1972

January 1–December 31, 1972, or other taxable year beginning 1972, ending 19

Please print or type

First name and initial (If joint return, use first names and middle initials of both) **Dr. Anthony & Mary** Last name **Napoli**
 Present home address (Number and street, including apartment number, or rural route) **1235 37 Street**
 City, town or post office, State and ZIP code **Brooklyn, N.Y.**

Your social security number (Husband's, if joint return) **057 26 2716**
 Wife's number, if joint return

Filing Status—check only one:

- 1 ☐ Single
 2 ☒ Married filing joint return (even if only one had income)
 3 ☐ Married filing separately. If wife (husband) is also filing give her (his) social security number and first

Exemptions

- Regular / 65 or over / Blind Enter number of boxes checked
- 6 Yourself ☒ ☐ ☐ 2
 7 Wife (husband) ☒ ☐ ☐
 8 First names of your dependent children who lived with you **Christopher** 2
Denise
 9 Number of other dependents (from line 32) Enter number
 10 Total exemptions claimed 2 4

Disclosure Limitations

Unauthorized disclosure, printing or publishing of any Federal return, copy, or part thereof, or information therefrom, is punishable by fine or imprisonment and dismissal from office or employment. See section 7213, Internal Revenue Code and section 1905, Title 18 U.S.C.

Department of the Treasury
 Internal Revenue Service



Notice 129 (1-70)

GPO c43-16-79468-1 369-581

- other employee compensation. (Attach Form W-2 to front. If unavailable, attach explanation) 11
- 12b Less exclusion \$ Balance 12c
- her distributions are over \$200, list in Part I of Schedule B.)
 0 or less, enter total without listing in Schedule B 13 775 29
 \$200, enter total and list in Part II of Schedule B 14 5927 20
 dividends, and interest (from line 45) 15
 13 and 14) 16
 such as "sick pay," moving expenses, etc. from line 50) 17 6702 49
 15 (adjusted gross income)
- and you could
 rent's return,
 or the heading
 block ☐ If you do not itemize deductions and line 17 is under \$10,000, find tax in Tables and enter on line 18. If you itemize deductions or line 17 is \$10,000 or more, go to line 51 to figure tax.

Tax Tables 1-12,

Schedule D

Tax Rate Schedule X, Y, or Z

Schedule G or Form 4726

- 61) 18 358
 19
 20
 21 444 54
 22 802 54
 23
 24 400
 25
 26

Tax, Payments

- 23 Total federal income tax withheld (attach Forms W-2 or W-2P to front) 23
 24 1972 Estimated tax payments (include amount allowed as credit from 1971 return) 24 400
 25 Amount paid with Form 4868, Application for Automatic Extension of Time to File U.S. Individual Income Tax Return 25
 26 Other payments (from line 71) 26
 27 Total (add lines 23, 24, 25, and 26) 27 400

Bal. Due or Refund

- 28 If line 22 is larger than line 27, enter BALANCE DUE IRS 28 402 54
 29 If line 27 is larger than line 22, enter amount OVERPAID 29
 30 Line 29 to be REFUNDED TO YOU 30
 31 Line 29 to be credited on 1973 estimated tax 31

Foreign Accounts

- Did you, at any time during the taxable year, have any interest in or signature or other authority over a bank, securities, or other financial account in a foreign country (except in a U.S. military banking facility operated by a U.S. financial institution)? If "Yes," attach Form 4683. (For definitions, see Form 4683.) ☐ Yes ☐ No

Note: Be sure to complete Revenue Sharing (lines 33 and 34) on next page.

Sign here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which he has any knowledge.

Your signature **Anthony Napoli** Date **1/13/73**
 Preparer's signature **William J. Smith** Date **1/13/73**
 Wife's (husband's) signature (if filing jointly, BOTH must sign even if only one had income) **Mary Napoli** Date **1/13/73**
 Address (and ZIP Code) **1235 37 Street Brooklyn, NY 11222** Preparer's Emp. Ident. of Soc. Sec. No.

Write soc. sec. no. on Check or Money Order. Attach here

SCHEDULE SE
Form 1040
Department of the Treasury
Internal Revenue Service

Computation of Social Security Self-Employment Tax

▶ Each self-employed person must file a Schedule SE.
▶ Attach to Form 1040.

1972

▶ If you had wages, including tips, of \$9,000 or more that were subject to social security taxes, do not fill in this page.
▶ If you had more than one business, combine profits and losses from all your businesses and farms on this Schedule SE.
Important: The self-employment income reported below will be credited to your social security record and used in figuring social security benefits.

NAME OF SELF-EMPLOYED PERSON (AS SHOWN ON SOCIAL SECURITY CARD)

Dr. Anthony Napoli

Social security number
of self-employed person
057 26 2716

Business activities subject to self-employment tax (grocery store, restaurant, farm, etc.) ▶ Chiropr Svc

Part I Computation of Net Earnings from BUSINESS Self-Employment (other than farming)

- 1 Net profit (or loss) shown in Schedule C (Form 1040), line 21. (Enter combined amount if more than one business.) 5927 20
- 2 Net income (or loss) from excluded services or sources included on line 1. Specify excluded services or sources 20
- 3 Net earnings (or loss) from business self-employment (Subtract line 2 from line 1, and enter here and on line 8(a), below.)

Part II Computation of Net Earnings from FARM Self-Employment

A farmer may elect to compute net farm earnings using the **OPTIONAL METHOD** (line 6, below) **INSTEAD OF THE REGULAR METHOD** (line 5, below) if his gross profits are: (1) \$2,400 or less, or (2) more than \$2,400 and net profits are less than \$1,600. If your gross profits from farming are not more than \$2,400 and you elect to use the optional method, you need not complete lines 4 and 5.

Computation under Regular Method

- 4 Net farm profit (or loss) from:
 - (a) Schedule F, line 54 (cash method), or line 74 (accrual method)
 - (b) Farm partnerships
- 5 Net earnings from self-employment from farming. Add lines 4(a) and (b).

Computation under Optional Method

- 6 If gross profits from farming are:
 - (a) Not more than \$2,400, enter two-thirds of the gross profits.
 - (b) More than \$2,400 and the net farm profit is less than \$1,600, enter \$1,600.

*Note.—Gross profits from farming are the total of the gross profits from Schedule F, line 28 (cash method), or line 72 (accrual method), plus the distributive share of gross profit from farm partnerships as explained in instructions for Schedule SE.

- 7 Enter here and on line 8(b), below, the amount on line 5 (or line 6, if you use the optional method)

Part III Computation of Social Security Self-Employment Tax

- 8 Net earnings (or loss) from self-employment—
 - (a) From business (other than farming) from line 3, above 5927 20
 - (b) From farming (from line 7, above)
 - (c) From partnerships, joint ventures, etc. (other than farming)
 - (d) From service as a minister, member of a religious order, or a Christian Science practitioner. If you filed Form 4361, check here ☐ and enter zero on this line
 - (e) From service with a foreign government or international organization
 - (f) Other (director's fees, etc.). Specify
- 9 Total net earnings (or loss) from self-employment reported on line 8. (If line 9 is less than \$400, you are not subject to self-employment tax. Do not fill in rest of page.) 5927 20
- 10 The largest amount of combined wages and self-employment earnings subject to social security tax for 1972 is \$9,000 00
- 11 (a) Total "FICA" wages as indicated on Form W-2 00
(b) Unreported tips, if any, subject to FICA tax from Form 4137, line 9 00
(c) Total of lines 11(a) and 11(b)
- 12 Balance (subtract line 11(c) from line 10)
- 13 Self-employment income—line 9 or 12, whichever is smaller 444 54
- 14 If line 13 is \$9,000, enter \$675.00; if less, multiply the amount on line 13 by .075 54
- 15 Railroad employee's and railroad employee representative's adjustment for hospital insurance benefits tax from Form 4469 54
- 16 Self-employment tax (subtract line 15 from line 14). Enter here and on Form 1040, line 62 54

E.C.
1040)**Profit (or Loss) From Business or Profession**
(Sole Proprietorship)**1972**Department of the Treasury
Internal Revenue Service

- ▶ Attach to Form 1040.
▶ Partnerships, joint ventures, etc., must file Form 1065.

Social security number

Name(s) as shown on Form 1040

Dr. Anthony & Mary Napoli

67-1001 2712

A Principal business activity Chiropractor; product Chiropractor
(See Schedule C Instructions) (For example: retail—hardware; wholesale—tobacco; services—legal; manufacturing—furniture, etc.)

B Business name Dr. Napoli C Employer Identification Number

D Business address (number and street) 84-04 13 Ave
City, State and ZIP code Bklyn, N.Y.

E Indicate method of accounting: (1) ☒ cash; (2) ☐ accrual; (3) ☐ other.

F Were you required to file Form 1096 for 1972? (See Schedule C Instructions) ☐ YES ☒ NO. If "Yes," where filed? ▶

G Is this business located within the boundaries of the city, town, etc., indicated? ☒ YES ☐ NO.

H Did you own this business at the end of 1972? ☒ YES ☐ NO.

I How many months in 1972 did you own this business? 12

J Was an Employer's Quarterly Federal Tax Return, Form 941, filed for this business for any quarter in 1972? ☐ YES ☒ NO.

IMPORTANT—All applicable lines and schedules must be filled in.

INCOME		DEDUCTIONS	
1	Gross receipts or sales \$	Less returns and allowances \$	Balance ▶
			22096 81
2	Less: Cost of goods sold and/or operations (Schedule C-1, line 8)		
3	Gross profit		
4	Other income (attach schedule)		
5	TOTAL income (add lines 3 and 4)		22096 81
6	Depreciation (explain in Schedule C-2)		316 19
7	Taxes on business and business property (explain in Schedule C-3)		1765
8	Rent on business property		
9	Repairs (explain in Schedule C-3)		
10	Salaries and wages not included on line 3, Schedule C-1 (exclude any paid to yourself)		365
11	Insurance		50
12	Legal and professional fees		
13	Commissions		
14	Amortization (attach statement)		
15	(a) Pension and profit-sharing plans (see Schedule C Instructions)		
	(b) Employee benefit programs (see Schedule C Instructions)		
16	Interest on business indebtedness		
17	Bad debts arising from sales or services		
18	Depletion		
19	Other business expenses (specify):		
(a)	Misc supplies & equipment	1481	09
(b)	Prof dues & societies	440	
(c)	Post	71	
(d)	Gown Cleaning	34	65
(e)	Electric	165	09
(f)	Seminars	210	
(g)	Telephone	199	24
(h)	Lic	45	
(i)	Office cleaning	720	
(j)	Books & Periodicals	84	60
(k)	Med fact cost & admist Cost	9027	
(l)	Auto Gas	556	45
(m)	Tolls & Parking	639	30
(n)			
(o)			
(p)	Total other business expenses (add lines 19(a) through 19(o))		13673 42
20	Total deductions (add lines 6 through 19)		16169 61
21	Net profit (or loss) (subtract line 20 from line 5). Enter here and on line 35, Form 1040. ALSO enter on Schedule SE, line 1		5927 20

SCHEDULE C-1. COST OF GOODS SOLD AND/OR OPERATIONS (See Schedule C Instructions for line 2)

Inventory at beginning of year (if different from last year's closing inventory, attach explanation)		
2 Purchases \$	Less cost of items withdrawn for personal use \$	Balance ▶
3 Cost of labor (do not include salary paid to yourself)		
4 Materials and supplies		
5 Other costs (attach schedule)		
6 Total of lines 1 through 5		
7 Less: Inventory at end of year		
8 Cost of goods sold and/or operations. Enter here and on line 2, page 1.		

Method of inventory valuation ▶

Was there any substantial change in the manner of determining quantities, costs, or valuations between the opening and closing inventories? ☐ YES ☐ NO. If "Yes," attach explanation.

SCHEDULE C-2. DEPRECIATION (See Schedule C Instructions for line 6)

Note: If depreciation is computed by using the Class Life (ADR) System for assets placed in service after December 31, 1970, or the Guideline Class Life System for assets placed in service before January 1, 1971, you must file Form 4832 (Class Life (ADR) System) or Form 5006 (Guideline Class Life System). Except as otherwise expressly provided in income tax regulations sections 1.167(a)-11(c)(5)(vi) and 1.167(a)-12, the provisions of Revenue Procedures 62-21 and 65-13 are not applicable for taxable years ending after December 31, 1970. If you need more space, use Form 4562.

Check box if you made an election this taxable year to use ☐ Class Life (ADR) System and/or ☐ Guideline Class Life System.

a. Group and guideline class or description of property	b. Date acquired	c. Cost or other basis	d. Depreciation allowed or allowable in prior years	e. Method of computing depreciation	f. Life or rate	g. Depreciation for this year
1 Total additional first year depreciation (do not include in items below)						
2 Depreciation from Form 4832						
3 Depreciation from Form 5006						
4 Other depreciation:						
Buildings						
Furniture and fixtures						
Transportation equipment	Var	3161.87	2141.40		10%	316 19
Machinery and other equipment						
Other (specify)						
5 Totals						
6 Less amount of depreciation claimed in Schedule C-1						
7 Balance—Enter here and on page 1, line 6						316 19

SUMMARY OF DEPRECIATION (Other Than Additional First Year Depreciation)

	Straight line	Declining balance	Sum of the years digits	Units of production	Other (specify)	Total
1 Depreciation from Form 4832						
2 Depreciation from Form 5006						
3 Other						

SCHEDULE C-3. EXPLANATION OF LINES 7 AND 9

Line No.	Explanation	Amount	Line No.	Explanation	Amount
		\$			\$

SCHEDULE C-4. EXPENSE ACCOUNT INFORMATION (See Schedule C Instructions for Schedule C-4)

Enter information with regard to yourself and your five highest paid employees. In determining the five highest paid employees, expense account allowances must be added to their salaries and wages. However, the information need not be submitted for any employee for whom the combined amount is less than \$10,000, or for yourself if your expense account allowance plus line 21, page 1, is less than \$10,000.

Did you claim a deduction for expenses connected with:

- (1) Entertainment facility (boat, resort, ranch, etc.)? ☐ YES ☐ NO (3) Employees' families at conventions or meetings? ☐ YES ☐ NO
 (2) Living accommodations (except employees on business)? ☐ YES ☐ NO (4) Employee or family vacations not reported on Form W-2? ☐ YES ☐ NO

Name	Expense account	Salaries and Wages
Owner		
1		
2		
3		
4		
5		

Schedule B--Dividend and Interest Income

is shown on Form 1040 (Do not enter name and social security number if shown on other side)

Dr. Anthony & Mary Napoli

Your social security number

PAY Dividend Income

Note: If gross dividends (including capital gain distributions) and other distributions on stock are \$200 or less, do not complete this part. But enter gross dividends less the sum of capital gain distributions and non-taxable distributions, if any, on Form 1040, line 12a (see note below).

- 1 Gross dividends (including capital gain distributions) and other distributions on stock. (List payers and amounts—write (H), (W), (J), for stock held by husband, wife, or jointly)

Part II Interest Income

Note: If interest is \$200 or less, do not complete this part. But enter amount of interest received on Form 1040, line 13.

- 7 Interest includes earnings from savings and loan associations, mutual savings banks, cooperative banks, and credit unions as well as interest on bank deposits, bonds, tax refunds, etc. Interest also includes original issue discount on bonds and other evidences of indebtedness (see instructions on page 13). (List payers and amounts)

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- | | | |
|---|--|--|
| 2 | Total of line 1 | |
| 3 | Capital gain distributions (see instructions on page 13. Enter here and on Schedule D, line 7). See note below | |
| 4 | Nontaxable distributions (see instructions on page 13) | |
| 5 | Total (add lines 3 and 4) | |

- 5** Total (add lines 3 and 4)

- Dividends before exclusion** (subtract line 5 from line 2). Enter here and on Form 1040, line 12a

- 8** Total interest income. Enter here and on Form 1040, line 13

Note: If you received capital gain distributions and do not need Schedule D to report any other gains or losses or to compute the alternative tax, do not file that schedule. Instead, enter 50 percent of capital gain distributions on Form 1040, line 41.

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EXHIBIT 28 - 1972 CALENDAR
(pp. E36-E37)

1972

EMTWTFS	SMTWTFS	SMTWTFS
JANUARY	FEBRUARY	MARCH
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
APRIL	MAY	JUNE
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
JULY	AUGUST	SEPTEMBER
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
OCTOBER	NOVEMBER	DECEMBER
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

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If you keep this card with you, it will keep you up-to-date on the New York State Bank Holidays for 1972. Note the four starred (*) holidays, indicating new federally-designated dates.

*February 21, Monday	Washington's Birthday
*May 29, Monday	Memorial Day
July 4, Tuesday	Independence Day
September 4, Monday	Labor Day
*October 9, Monday	Columbus Day
*October 23, Monday	Veteran's Day
November 7, Tuesday	Election Day
November 23, Thursday	Thanksgiving Day
December 25, Monday	Christmas Day

* Federally designated holiday

EXHIBIT - GRAND JURY MINUTES DATED JANUARY 16, 1975
(pp. E38-E77)

UNITED STATES GRAND JURY

SOUTHERN DISTRICT OF NEW YORK

----- x
:
UNITED STATES OF AMERICA :
:
-v- :
:
JOSEPH INGBER, :
SHELDON STYLES, et al. :
----- x

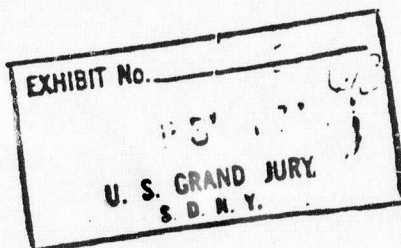
United States Court House
Foley Square
New York, New York

Thursday, January 16, 1975
2:00 o'clock, p.m.

APPEARANCES:

SHIRAH NEIMAN,

Assistant United States Attorney



William Vorsteg
Acting Grand Jury Reporter

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FIVE WORLD TRADE CENTER
NEW YORK, N. Y. 10047
[212] 466-1280

NANCY ROSNER

ANTHONY NAPOLI, called as a witness,
having been duly sworn by the Forelady of the Grand
Jury, testified as follows:

BY MS. NEIMAN:

Q Would you please state and spell your full name for
the record?

A Anthony Napoli, N-a-p-o-l-i.

Q Dr. Napoli, I would like you to listen very care-
fully. I'm going to advise you of your rights and I want
you to indicate when I've finished whether you've understood
what I've said.

The Grand Jury is investigating Medicaid fraud, and
the scope of the investigation is into all physicians, para-
physicians, owners, secretaries, or anyone related to clinics
run by Dr. Joseph Ingber and Mr. Sheldon Styles. The fraud
that is being investigated is the submission of fictitious
invoices to the city in connection with Medicaid payments.
Medicaid is funded 50 cents on the dollar by the Federal
Government and that is why we have jurisdiction in this
case.

The federal criminal laws which are involved, among
others, are the two mentioned on the subpoena which brought
you here. The first is conspiracy, and that relates to
conspiracy to defraud the Health, Education and Welfare

1
2 Department, and conspiracy to submit false claims to the
3 government.

4 The other statute cited on the subpoena is the sub-
5 mission of false crimes against the government. And there are
6 other aspects to the filing of the false document.

7 This Grand Jury may return indictments against various
8 people. As someone who possibly worked at one of these
9 centers, you are potentially a target if you were in any way
10 involved in any fraud if a fraud is found to have existed.
11 You have the right to refuse to answer any questions which
12 may tend to incriminate you, in other words, which may tend
13 to show that you are guilty of a crime.

14 You have the right to have an attorney present out-
15 side the Grand Jury room and to consult with that attorney
16 at any time. In other words, you can leave the room and
17 confer with your attorney after each and every question that
18 I ask.

19 Anything that you do answer here can be used against
20 you at a later proceeding, including a subsequent criminal
21 trial if that should arise in your case.

22 If you willfully testify falsely before the Grand
23 Jury you can be indicted for perjury.

24 Do you understand all of those?

25 A Yes, I do.

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Q Do you wish to proceed?

A Yes.

Q Would you give us your home address and phone number and then your business address and phone number?

A My home address is 611 Lamoka Avenue, L-a-m-o-k-a, Staten Island. Telephone number at home is 356-7409.

My office is 8404 Thirteenth Avenue, Brooklyn. The number there is 833-5189.

Q And what is your social security number? Do you know it by heart?

A 056-26 -- please let me check.

057-26-2716.

Q What kind of physician are you, using that word in the broadest sense?

A Chiropractic.

Q And were you licensed by the State of New York?

A Yes.

Q And when?

A 196-- oh, no. Licensed '71. Or '70-- '71, yes, '71.

Q And were you licensed at that time to take X-rays?

A Yes.

Q At the same time as your license?

A Yes.

Q Do you know Dr. Joseph Ingber?

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A Don't know him personally.

Q Have you heard about him?

A Oh, yes.

Q Do you know Mr. Sheldon Styles personally?

A No, I don't.

Q Have you heard about him?

A Yes.

Q Did there come a time that you joined a clinic which they either owned, ran or operated?

A Beg pardon?

Q Did there come a time when you joined a clinic which they either owned, ran or operated?

A I went into a clinic at 858 Flushing Avenue, known as the Galler Medical Center.

Q G-a-l-l-e-r?

A Yes, right.

Q Spell all names, please.

A I'm sorry.

Q It's not your fault.

A Okay. I never saw or met them but I knew that they had some -- something to do with that particular center.

Q Was it your understanding that they had an ownership interest in the center?

A Yes.

1 Q And approximately when did you join that center?

2 A 1971, the month of, I believe, February or March. I
3 don't know exactly the month, one of those months.

4 Q That's when you came to the center?

5 A That's when I went to it, yes.

6 Q How did you get to the center?

7 A I answered an ad in the paper, an ad asking for
8 chiropractors in Medicaid centers. And I rang a phone number.
9 At the time I got a recording. And I wasn't told who I was
10 speaking to. But later, I don't remember whether it was in
11 that week or that month, I don't recall that, but I was
12 returned the call and I believe that was Dr. Ingber. And he
13 told me if I was interested in working in a Medicaid center
14 that I could go to this one and work there, meaning the one,
15 Galler, the one I previously mentioned.

16 Q Did you have any discussion about the fee arrangement
17 that you would have with the center?

18 A No, not at that time.

19 Q And what did Ingber tell you to do?

20 A To go down and see the administrator.

21 Q And who was that?

22 A That was Dr. Max K-a-v-a-l-e-r. Max Kavalier.

23 Q And did you do that?

24 A Yes.

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Q And would you tell us what discussion you had with Dr. Kavalier?

A When I went there I was explained the procedure. Now, this at the time was all quite new to me. And it was explained that a percentage of my income would go to these, Ingber and Styles, and a percentage of that also to go to the rental of the house.

Q And would you tell us what the per cents were and--

A Beg pardon?

Q What was the per cent rental?

A Rental was I believe 30 per cent and 20 per cent to both the other fellows, Ingber and Styles.

Q Did you agree to that?

A Yes.

Q Was that put in writing or verbal?

A No. It was verbal.

Q And what were the hours that you agreed to keep there?

A I don't remember the exact days, but it was a three-day schedule that I had or that was open. I don't remember the exact days, could have been either Tuesdays and Thursdays and Saturdays, or Mondays, Wednesdays and Saturdays. This I don't remember but records could tell what days I was there by calendar days.

Q Did you work anywhere else at the same time?

1
2 A Oh, not at that time. Oh, yes, the other days I was
3 in my own private office.

4 Q Where was that?

5 A 8404 Thirteenth Avenue.

6 Q What borough?

7 A Brooklyn.

8 Q So that on the alternate days when you were not at
9 the clinic --

10 A I was at my private office.

11 Q And did you work on the same three days throughout
12 the time that you worked at the clinic?

13 A My --

14 Q Did you keep the same three, whether it was a Monday,
15 Wednesday and Saturday, the Tuesday, Thursday, Saturday --

16 A Throughout the time I was there, yes, as I recall I
17 did.

18 Q What were your hours?

19 A 9:00 to 5:30, 6:00 o'clock, 6:30. It depended on the
20 load of patients that the clinic would have at the time.

21 Q And on Saturday?

22 A Saturday was from 9:00 to about 4:00, 3:00, like this.
23 Precisely I can't recall the exact time but it was in this
24 vein.

25 Q Did you ever meet Ingber while you were at the clinic?

1 A No, I did not.

2 Q Would you tell us when you left the clinic?

3 A I left the clinic around March or April of '72. Now,
4 at that time I left and spent time splitting those days that
5 I was going to Galler at another medical center. Understood?
6

7 Q No.

8 A In other words, when I was lessening my time at Galler,
9 I was cutting my time there and starting to work at another
10 center. But on those days, only splitting those days.

11 Q In other words, if it was Monday, Wednesday and
12 Saturday, you split those three days in half and you worked
13 half at one clinic and half at Galler?

14 A That's right, and this was at the latter part of my
15 time spent at Galler.

16 Q And that was beginning when, March and April or --

17 A Well --

18 Q Is that the beginning of the splitting or the end?

19 A I can't remember precisely. It was towards -- the
20 time I spent at Galler was roughly a year and two or three
21 months, something like this.

22 It was like the latter part of that time at Galler,
23 such as, I don't know, three, four months or so that I
24 started to split and go to the other place.

25 Q And what was the other clinic's name?

1
2 A I don't remember the precise name but the address was
3 166A Lee Avenue.

4 Q Did that have anything to do, to your knowledge, with
5 the Galler Clinic?

6 A No.

7 Q And on what schedule were you? Did you work mornings
8 or afternoons there?

9 A It varied. Sometimes it varied, depending on what
10 my schedule was for my patients at Galler.

11 Most times, as I recall, it was in the latter part.
12 In other words, from like say 2:00 o'clock, 1:00 o'clock,
13 3:00 o'clock I would leave Galler and then go to the other.
14 Again, here, the time is not precise because I can't recall,
15 exactly that is.

16 Q What was the maximum number of hours you worked at
17 Galler during this latter period of time, on a given day?

18 A Five, five and a half, four hours.

19 Q And at the other clinic how many?

20 A About three and a half, four, not precisely now.
21 But the rest of the evening would be spent at the other
22 clinic, the Lee Avenue one.

23 Q To whom was the rental check to be made out?

24 A Which --

25 Q To whom was the 30 per cent rental check to be made

1
2 out to?

3 A At Galler this is now?

4 Q Yes, at Galler.

5 A I believe it was made out to Galler Medical Center.

6 Q Wouldn't it have been made out to the 858 Flushing
7 Corporation, the corporate title?

8 A Yes, it could be that. I think that's what it was,
9 it was 858 Flushing Avenue Corporation. That's what they called
10 it, I believe, yes.

11 Q Did you factor your accounts?

12 A Yes, I did.

13 Q With whom?

14 A Blum. I forget his first name.

15 Q Joseph?

16 A Joseph Blum, yes.

17 Q And did you begin to factor your accounts when you
18 came to Galler?

19 A Oh, yes.

20 Q And did anyone ask you to do that or require that as
21 a condition of your employment?

22 A It wasn't required but it was suggested that this was
23 the routine thing. At the time, when I says, when I first
24 went into Galler, I knew nothing about the functioning of a
25 Medicaid system as such, and what was told me I believed or

1 was led to believe this was the way it functioned, period.

2 Q And who told you that?

3 A The administrator, Dr. Kavalier.

4 Q And what percentage of the gross Medicaid billings
5 that you told over to Mr. Blum did he charge you as a fee?

6 A I believe it was 12 per cent.

7 Q Did anyone inform you that Ingber and Styles were
8 receiving a kickback out of that 12 per cent?

9 A No.

10 Q Did you ever learn that from anybody or hear that
11 from anyone?

12 A No.

13 Q And was it 30 per cent of the balance after the
14 factor?

15 A After factor, yes.

16 Q That you paid to the clinic?

17 A Yes.

18 Q And then above that, of the balance, you paid 20 per
19 cent to Ingber and Styles?

20 A Yes.

21 Q Did you pay the clinic by personal check?

22 A Yes.

23 Q And did you pay Ingber and Styles by personal check?

24 A Yes.

1
2 Q And to which of those two gentlemen did you write
3 the check?

4 A To both, both to Ingber, one to Ingber and one to
5 Styles.

6 Q You split the 20 per cent into 10?

7 A Yes.

8 Q Did you ever give them cash?

9 A No.

10 Q Did they ever ask for cash?

11 A No. I never -- after that first discussion on the
12 phone I never ever saw or heard of either one of them after-
13 wards.

14 Q To whom did you give the checks?

15 A I left them with Dr. Kavalier.

16 Q And was he the one to whom you gave the corporate
17 check?

18 A Yes.

19 Q And what were you paying Ingber and Styles for, what
20 was the 20 per cent for?

21 A Administrative services, I was told.

22 Q Did you keep patient records at the Galler clinic?

23 A Oh, yes.

24 Q Did you organize your own records, or were they
25 organized for you?

1
2 A No, my own records.

3 Q And would you describe the kind of records you kept?

4 A Case history, copies of the treatment plans were sent
5 in for those cases that needed further treatment, the dates--

6 Q Let's start with the case history. Did you have a
7 special kind of card?

8 A Yes. I had a regular case history card that would,
9 you know, write down the particular complaint of the patient.

10 Q A chart or a 3 x 7 or a 5 x 8?

11 A No, it's a 5 x 8, yes, a 5 x 8.

12 Q And on subsequent visits, would you enter the patients
13 visit on that card?

14 A Yes, dates on that card, normally the reverse side
15 of it.

16 Q So all of the information on the patient, unless the
17 patient came many, many times, would be on that card?

18 A All of it would be on that card, yes.

19 Q And when you ran out of space on that card, if
20 necessary, you would just attach another card of the same kind?

21 A That's right. Or if a case had to be continued on,
22 as some cases were, needed additional care, on a particular
23 problem.

24 Q And did you keep any diary or daily record of the
25 patients who you saw?

1 A When you say diary, do you mean a dating system?

2 Q A diary book, a dating system?

3 A I had a day book. Now, from the time that I worked at
4 Galler, after that time, I have since moved from Brooklyn to
5 Staten Island. The date book I had and I also passed this
6 day book on to an inspector who had come in to me in reference
7 to this same problem. I don't remember when.

8 Q What do you mean by passed it on, you gave him the
9 original?

10 A Yes, I did have a day book. I gave him the book.
11 And after inspecting the book he kept it in his possession
12 for a short period and then returned it to me. However, I
13 don't know where the book exists now. But the same dates
14 that exist in that book exist on the files that I have on
15 the regular patients.

16 Q You don't know what happened to the original once you
17 got it back?

18 A Y'es, because in the moving it's disheveled. As a
19 matter of fact, I had a difficult time finding the records I
20 have at present for the Galler Center.

21 Q Is that Postal Inspector Zurick?

22 A Yes.

23 MS. NEIMAN: May this be marked Grand Jury

24 Exhibit 53.

(So marked)

1
2 BY MS. NEWMAN:

3 Q Does this appear to be a copy of your day book, Grand
4 Jury Exhibit 53?

5 A Yes, yes, this is it.

6 Q And are the entries in here all in your handwriting?

7 A Yes.

8 Q What do they represent, appointments made in advance
9 or people who came in?

10 A Both, people who came in and appointments made in
11 advance.

12 Q So that if someone saw you on a Monday, if that was
13 the day in which you worked, and I guess by looking at this
14 we can tell?

15 A That patient was in that day.

16 Q Can you look through this and tell us whether it was
17 Monday, Wednesday and Saturday?

18 A The dates correspond, these days here correspond, to
19 the specific days.

20 Q So it was Monday, Wednesday, and Saturday.

21 A Yes, fine, that's it. That's right.

22 Q Now, when a patient came in and you were going to
23 have that patient come back, you'd make an appointment and
24 you would put it in the day book?

25 A Yes.

1 Q For a particular hour?

2 A The hour is difficult because these patients, most
3 of these patients, let me say, had a very poor sense of time.
4 So if I would say 1:00 o'clock, it could be 12:00, it could
5 be 2:00.
6

7 Q I didn't ask you when they came in, what did you do
8 with their name in terms of putting it in the day book? Did
9 you put it in the day book?

10 A Yes.

11 Q Did you just pick an hour and put it on there?

12 A Yes, I would tell them.

13 Q And you put their name next to that time?

14 A Right.

15 Q And this is when you made the appointment with them?

16 A Yes. This was in the beginning. This changed later on.

17 Q Wait, please.

18 Now, when on that particular day the patient came in,
19 but at a different hour, I take it you didn't cross his name
20 out, just left his name in there?

21 A That's what I want to clarify now.

22 Q Just answer that question.

23 A Ask the question again, please.

24 Q When a patient came in, if it was a different hour,
25 did you cross his name out and put it at the right hour or

1 just leave it there?

2 A No, I left it there.

3 Q When patients came in who had not made an appointment,
4 did you put their name at the hour at which you saw them?

5 A No, they were crossed off. They were crossed off.
6 Because, you see, if I would continue to keep names that
7 didn't show up, I don't have a great deal of space, because
8 sometimes these pages are rather full, as you see here. So
9 in the beginning I used to ink these in, and it tended to
10 make a very messy appearance. And I used to pencil them,
11 erase it and put the proper name that came in at the time.
12

13 THE FORELADY: His voice is inaudible.

14 Q You will have to speak louder. If you would speak
15 louder, please.

16 A Okay.

17 Q Let's try this again. If a patient came in at a dif-
18 ferent time, you erased his name and you started using
19 pencil?

20 A No, if the patient came in, the name wasn't erased.
21 As a matter of fact, I'm not even so sure I would put the
22 name in advance because it got --

23 Q Please think about it. It's important.

24 A You see a patient would be given a time to come in.
25 Now, as I said, often these patients have a poor sense of the

right time or whatever the reason may be. And so the book could tend to become rather messy by scratching out a name and replacing it by another, what have you.

So in the beginning I used to enter a name in the book and leave it on as such. However, as the practice went on and I noted that some patients would not keep a schedule as such, they would -- it would tend to make a messy book. So I started to eliminate putting them in in advance but giving them appointment cards, so they would take it with them and come in. As they would come in, then I would enter them in the book.

Q So towards the -- so towards what month into your practice approximately did you begin to do that?

A I really wouldn't remember.

Q Was it two or six?

A More like two I would say. I would say about two.

Q So let's take May 5th, for example, would the list of names that appear here beginning at 8:45 and going through to 6:30 be people who saw you that day and whose names you wrote into the day book either as they came in or when they went out?

A As they came in.

Q As they came in.

Dr. Napoli, there are some Tuesdays filled in here

1
2 in addition to some Mondays, Wednesdays and Thursdays, do
3 you have any recollection of why that is?

4 A There's a reason for it. And I'll think in a moment.

5 As I said, here's a time when lines were absent.
6 There weren't enough lines on the paper to cover some of the
7 names and they might have been crossed over the next day.

8 Q So if there are some Tuesdays and Thursdays, it
9 really should correlate to whatever is on the right side of
10 the page?

11 A That's right.

12 Q As an example, for the record, Dr. Napoli was looking
13 at May 12th, Wednesday, 1971 and on the left of the page is
14 May 11th, and a lot of space was taken up on the May 12th
15 Wednesday page and there are several names listed on the
16 Tuesday page.

17 And it's your recollection that the names over here
18 were put here because they just didn't fit on this side of
19 the page?

20 A Yes. Now, later on in the book when I started to
21 work with the other center, these names now, I started using
22 other dates because -- the same reason actually, because of
23 an overflow of names on one page.

24 Q Did you use this book for the other center, also?

25 A Yes.

1
2 Q Is there any way that we can distinguish which patients
3 come from which center?

4 A No.

5 Q Other than that they should be on the right days?

6 A No. The files, my records would have my patients in
7 the right place.

8 Q And are you the only one who wrote anything in this
9 book?

10 A Yes.

11 Q And do you have the patient records, the charts?

12 A Yes.

13 Q Did you bring them with you?

14 A Yes, I did.

15 Q Would you produce them.

16 A I have them outside. Shall I get them?

17 MS. NEIMAN: Would you excuse him to get them.

18 THE FORELADY: You are excused temporarily.

19 (Discussion off the record.)

20 (Witness resumed.)

21 A These are the case records of the Galler Center.

22 Q And that's just Galler?

23 A Yes.

24 MS. NEIMAN: Can we mark this stack of charts --

25 THE WITNESS: Case histories.

1
2 MS. NEIMAN: And which are goldish color and the
3 pink are what?

4 THE WITNESS: These are the treatment plans.

5 MS. NEIMAN: And there are some yellow progress
6 reports, is that what the yellow is?

7 THE WITNESS: There are some progress reports. There
8 are some X-ray reports, also.

9 MS. NEIMAN: Can we mark the entire batch as

10 54.

(So marked)

11 BY MS. NEIMAN:

12 Q Dr. Napoli, how come you took your records with you,
13 as opposed to leaving them at the center?

14 A They were my records.

15 Q What is your understanding of the procedure when a
16 physician leaves an area where he has practiced, what is he
17 supposed to do with patient records he has kept in connection
18 with his practice in that particular area, neighborhood I
19 mean?

20 A I don't know routinely. All I know is when I worked
21 at Galler, it was one room and there wasn't much room for,
22 you know, excess of files or what have you -- as a matter
23 of fact, these will be brought with me daily as I came into
24 the place, and brought home again with me. When the case was
25 finished, it would be brought home to my home and put away.

1
2 Q In other words, when a course of treatment was
3 finished with a particular patient?

4 A That's right.

5 Q Were there other chiropractors at Galler when you were
6 there?

7 A Oh, yes, on the other days I wasn't there there was
8 a Dr. Sidney Gerber.

9 Q And was he there the entire time period while you
10 were at Galler?

11 A I believe he was. I believe he was.

12 Q And did you ever see some of his patients who had
13 problems on days that you were there?

14 A Oh, sometimes they would come, you know, and look for
15 him, come to see him.

16 Q And look for him, come to see him?

17 A For treatment that is. And some of them would be in
18 acute pain and, therefore, I would treat them. However,
19 couldn't bill for this because they were already being cared
20 for by Dr. Gerber, so there would be a double billing, so I
21 wouldn't even do this.

22 Q Why would there be a double billing?

23 A I couldn't charge.

24 Q Wait for the question.

25 I would assume that they would -- only one of us

1
2 at a time can talk.

3 I would assume if he didn't see the patient he
4 wouldn't be billing for that patient, the bill comes after
5 the visit, why would this be double billing?

6 A I know. But on a treatment plan, the city allows you
7 whatever -- let us say you request ten additional visits.
8 And if it's okayed, then you would be the one to pay, to be
9 paid for for those treatments as you gave the treatments.

10 Now, if this patient belonged or was seeing Dr.
11 Gerber, then it would be a service that we would do for
12 each other. Many times a patient would come in for me on the
13 days I wasn't there, and he would adjust the patient for me
14 and vice versa. It was a courtesy we had with each other.

15 Q Did you let him know that you had seen a particular
16 patient?

17 A Yes, I would leave a notation on the desk, you know,
18 for him to see when he'd come.

19 Q And did he do the same for you?

20 A Oh, yes.

21 Q Were his records there for you to refer to when a
22 patient of his came in and had to see you?

23 A No.

24 Q And your records were not there for him to use?

25 A Right.

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Q And these records were kept apart from the records of other medical specialties as the clinic, is that correct?

A Yes.

Q Are you the only person who made entries on the patient charts, your own patient charts?

A Yes.

Q Can you tell us how you prepared your invoices?

A How I prepared my invoices?

Q Yes. Did you do them yourself?

A Oh, yes. It was all done by me. All of the work-up with the patient, the care, the invoicing was all done by me.

Q None of the people who worked at the clinic ever --

A No.

Q Wrote in anything on any of the invoices that you submitted?

A No.

Q And did you ever authorize anyone to sign your name?

A No.

Q Is that no?

A No.

Q And when did you prepare the invoice, right after you saw the patient?

A After the treatments were completed or the time allotted for the treatments were finished. And I don't know

1
2 exactly what time, the days, maybe a week or two, and it was
3 invoiced and then sent to the city.

4 Q In other words, if you saw a patient for 12 times,
5 because that was the treatment and you were finished, you
6 prepared the invoice at the end?

7 A Oh, yes.

8 Q And you prepared it from what records?

9 A From my records.

10 Q From the patient records?

11 A Yes.

12 Q Did anyone at Galler ever ask you to allow them to
13 prepare your invoices?

14 A No.

15 Q Do you know if anyone was preparing Dr. Gerber's
16 invoices other than Dr. Gerber?

17 A No.

18 Q Do you know Sheila Styles?

19 A Sheila Styles, no, I don't.

20 Q Did you ever hear of the name Sheila Styles?

21 A No.

22 Q Were you ever asked by anyone at the clinic to
23 falsify the invoices that you submitted to the city?

24 A No, never.

25 Q Did you ever hear from any physician or secretary

1 at the clinic that something like that was going on?

2 A No.

3 Q Can you describe how you dealt with Mr. Blum, the
4 procedures that you used?

5 A After a group of invoices was gathered, he would come
6 to the center on a certain day and I would pass over the
7 invoices to him. And he, in turn, would pass over the check
8 in reference to the amount on the invoices, and that was it.

9 Q And did he give you a settlement sheet, totaling the
10 number of invoices, the amount and the discount and the
11 balance?

12 A Yes. Yes, he did.

13 Q And that check was deposited by you in your bank
14 account?

15 A Yes.

16 Q Do you recall where your bank account was at the time?

17 A 13th Avenue, 55th Street, I believe. I think at
18 the time it was Manufacturers Hanover Trust or Chase, I don't
19 know, one of the two.

20 Q Do you still have the check stubs and deposit slips
21 and any other records from that bank?

22 A This is in '71, '72, I don't believe I do. I may.
23 But I don't believe -- I can't think offhand and say I do
24 have them or don't. It's a possibility.
25

1 MS. NEIMAN: I'm going to have the Forelady --

2 A Beg pardon --

3 MS. NEIMAN: The Forelady is going to direct you
4 to look for the bank statements and deposit slips which
5 might reflect the deposit of the factor's checks to that
6 bank account or any bank account in which you may have
7 deposited his checks.
8

9 A Yes.

10 MS. NEIMAN: Would you so direct Dr. Napoli.

11 THE FORELADY: You are so directed.

12 MS. NEIMAN: And any check stubs.

13 THE WITNESS: Right.

14 BY MS. NEIMAN:

15 Q And you would then write your personal check the same
16 day to the corporation and to Ingber and to Styles?

17 A Yes.

18 Q Did you have to pay any extra for any secretarial
19 services?

20 A No, I worked with no one else.

21 Q And were the personal checks from the same account?

22 A My account.

23 Q Were they written from the same account in which you
24 deposited the Blum checks, as a checking account?

25 A Yes.

1
2 Q So if you produce all of those records, it will cover
3 both --

4 A I will look for them and hope to produce them, yes.

5 Q And cancelled checks that you sent to Ingber and
6 Styles and the Corporation, if you have them?

7 A Yes.

8 Q Did you retain the pink copy of the invoices that
9 you sent to the city?

10 A I did for awhile. But after I was paid, then I
11 discarded them.

12 Q And so you did not bring any today at all?

13 A No. But those copies can be had from the city because
14 there were duplicates.

15 Q You gave up the original and the yellow copy to Mr.
16 Blum?

17 A Right.

18 Q When you sent in treatment plans, did you prepare
19 them entirely by yourself?

20 A Yes. I did.

21 Q No one else helped you in the preparation?

22 A No one else.

23 Q Did you prepare the treatment plan after the first
24 visit, second or third visit of the patient?

25 A After the third visit.

1
2 Q You had no procedure where you prepared it immediately
3 after the first visit?

4 A No. There was no way in knowing whether the patient
5 would need additional care or not until we reached that point.

6 Q And did you keep copies of the treatment plan?

7 A Yes, they are attached to the case histories.

8 Q And do you believe that all of them are there?

9 A I believe they are, yes.

10 Q And what about the progress reports, did you keep
11 copies of the progress reports?

12 A Whatever I had in reference to the case, case
13 history or patient, is at present here.

14 Q Were you given a copy or the original of a vendor
15 statement when Mr. Blum was paid by the city for the
16 invoices you submitted?

17 A I believe that I was. There, again, whether they can
18 be produced or not I don't know because they were together
19 with the invoices and the pink, you know, the pink copies
20 at the time.

21 Q And you don't have them to your knowledge?

22 A To my knowledge.

23 Q Do you recall the names of any other physicians who
24 worked at Galler?

25 A At Galler?

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Q Apart from Dr. Gerber?

A Dr. Hernsfield or Hirshfeld, was a pediatrician there at that time.

Q Were there any other chiropractors apart from Dr. Gerber?

A No. That is to say, none that I knew, because the days were occupied by Dr. Gerber, and then I was on the other days.

Q Do you know Marvin Mosner?

A Marvin Mosner, no.

Q Do you know Ira Feinberg?

A No.

Q Do you know George Garami, an MD?

A He was one of the fellows that used to come there. I don't know how frequent or what his schedule was, but that name is familiar, yes.

Q Did either Dr. Ingber or Mr. Styles work there, to your knowledge?

A No.

Q Did you know whether anyone who worked there worked at other clinics related to Styles or Ingber?

A No.

Q Did you ever work at any other clinics related to Styles or Ingber?

1
2 A No.

3 Q What about Kavalier?

4 A What about him?

5 Q Did you ever work at any other clinic that Dr. Kavalier
6 was associated with?

7 A No. This was my first encounter there.

8 Q And your last?

9 A With Galler?

10 Q With Dr. Kavalier?

11 A Oh, yes, that's right. After that, that was it.

12 Q Do you know what ping ponging is?

13 A Now I know, yes.

14 Q Why do you know now?

15 A From reading the papers and the problems that have
16 gone on in the Medicaid situation.

17 Q To your knowledge, was there any ping ponging at
18 the Galler clinic?

19 A Not at Galler, not to my knowledge.

20 Q Were you ever asked to refer anybody unnecessarily
21 to anybody else?

22 A No.

23 Q Were you ever told that every person who walked in
24 the clinic was required to see a chiropractor?

25 A Oh, no.

1
2 Q Did any patients ever come to you without chiro-
3 practic problems because they were simply ushered in to see
4 you?

5 A No, only muscular skeletal disorders were cared for.

6 Q Only muscular skeletal disorders were cared for?

7 A Were cared for.

8 Q Was there a particular surgical supply house that
9 you were asked to use?

10 A No. If there was any, it was unknown to me.

11 Q What about laboratory?

12 A Again, unknown to me, because I would have nothing
13 to do with that anyway.

14 Q And pharmacy?

15 A No.

16 Q Did you speak to anyone today about your appearance
17 here today other than your wife or attorney?

18 A I don't have an attorney. I spoke to a fellow that
19 I know, Dr. Arnie --

20 Q Lefkowitz?

21 A Lefkowitz, yes. I know him, for awhile, as a
22 colleague.

23 Q Did you ever work with him or at a clinic with him?

24 A No.

25 Q Did Mr. Styles or Dr. Ingber try to contact you?

1
2 A No.

3 MS. NEIMAN: May these two Queens Trading Cor-
4 poration files, Napoli, A., G. for Galler, N. for
5 Napoli, 2 and 3, be marked as Grand Jury Exhibit 55
6 and 56. (So marked)

7 Q Would you look through Grand Jury Exhibit 55 which,
8 after a settlement sheet from Mr. Blum, contains invoices
9 with your signature?

10 A That's right.

11 Q Can you tell us whether they all contain your
12 signature?

13 A Yes, they do. Yes, they do. They would have to
14 because I was the only one that signed my name to any of
15 these things. This is the sheet from Mr. Blum.

16 Q Just look through the invoices and tell us whether
17 your signature is on all of them?

18 A Yes, ma'am.

19 Q And would you look through 56, and just tell us
20 the same thing, whether you see a signature which is not
21 yours but someone else's?

22 A This one is missing.

23 Q Missing a signature?

24 A yes.

25 These are all mine.

Q The second batch in Grand Jury Exhibit 56 is typed in, who did that?

A My wife.

Q And the top is also typed or is it a --

A This?

Q A credit card type stamp?

A Oh, no, typed.

Q Dr. Napoli, did you ever submit a fictitious invoice in the sense that you either billed for a patient you had not seen or billed in excess of a number of visits you actually administered?

A No, I have not.

Q Can you tell us what the average amount of time it takes to give a chiropractic adjustment to someone who needs or has some problem?

A The adjustment itself, the adjustment itself, under a minute.

Q And what else is it that you do? Give us some examples apart from the minute that is spent with the patient.

A After the case history is taken, which would take anywhere from six to eight minutes --

Q That's on the first visit?

A That's the first visit, then after that, after the findings and analysis, then the doctor decides what kind of

1
2 adjusting is to be given to a particular patient for the
3 particular complaint.

4 And after that, on subsequent visits, the treatment
5 is carried through as such, as is decided by the doctor.

6 Q And about how, if it is decided that treatment is
7 necessary, about how long a period of time in minutes or
8 half hours does a particular treatment require?

9 A I'm not sure I understand the question.

10 Q Let's say you are treating someone for sciatica.
11 How long would the visit of that patient be for that par-
12 ticular day when he is coming?

13 A For that particular problem?

14 Q Yes.

15 A A minute, two minutes the most, depending upon what
16 segments and what areas have to be corrected.

17 Q So that person would come 12 times for two minutes
18 each, is that basically?

19 A Yes, that's basically about the size of it.

20 Q What do you do in those two minutes?

21 A Adjust the particular vertebra involved for the
22 particular condition.

23 Q And that gets done on the first visit and then that
24 gets done on the second and third and fourth all the way
25 through the twelfth, the same thing?

1
2 A Yes, because correction doesn't just happen, you
3 know, with the adjustment per se. It's a process of time
4 allowed for the body to accept the correction. And each time
5 it's done until finally the correction is held by the body
6 and then the problem is helped or alleviated.

7 Q What about bursitis, how many minutes does that
8 take after the first visit?

9 A Again, we are dealing with adjusting segments of the
10 spine. The actual adjusting itself is a very, very short
11 span, a very short time. Even at that, a minute is more than
12 sufficient to make the particular adjusting for the particular--
13 because, when you are making adjustments as such, you are
14 talking about a vertebral segment and it doesn't take a
15 great deal of time to make an adjustment as such.

16 Q Do you do anything else other than that when the
17 patient comes to visit you?

18 A No, predominantly that. Sometimes, depending, if there
19 was soft tissue damage or hurt or a problem lying therein,
20 then it would be cared with some soft manipulative tissue
21 work and here again it wasn't a long procedure either. It
22 would be itself, also approximately a minute.

23 Q So you could easily see 50 patients a day?

24 A You could, you could.

25 Q Is that the average of patients that you saw on a given

1
2 day?

3 A I never saw that many.

4 Q What was the most patients you think you saw when you
5 were at Galler?

6 A 35, 40, 45, like this.

7 Q But not 50 or 55?

8 A Oh, I'm not saying you couldn't. You probably could.
9 There may have been times I may have seen 50. But the point
10 is more than this amount, more than 55, you'd have to be
11 working pretty hard. But it could be done.

12 Q When you submitted a treatment plan and recommended
13 the course of treatment which was approved by the city,
14 was that the course of treatment which you followed, if it
15 was approved?

16 A Yes.

17 Q Why did you leave the Galler clinic, any particular
18 reason?

19 A Yes. So that I could earn more money, because the
20 percentage that I was paying there, you know, between the
21 factor and what I was paying the house and what have you, it
22 didn't leave very much for me. And this is why I started to
23 diminish my time at Galler to go to the other, to the Lee
24 Avenue Center.

25 Q Was your percentage ever changed while you were at

1
2 Galler?

3 A No.

4 Q You continued to give 20 per cent to Ingber and
5 Styles throughout the time you were there?

6 A Yes.

7 MS. NEIMAN: Okay. I have no further questions
8 for Dr. Napoli. But you will recall that you've been
9 directed to produce the check statements and the check
10 stubs and any cancelled checks which you have from
11 that account.

12 A All right.

13 Q Or any accounts, if it is plural.

14 A Now, in bringing these in, can it be either a
15 Tuesday or a Thursday, may I request that?

16 Q You can, if you wish, have them mailed certified or
17 registered mail.

18 A Oh, fine.

19 Q To my office.

20 A Fine.

21 Q Or if you wish you can send a messenger or come any
22 time that you want if you come in advance. Would two weeks
23 be enough to get them together if you do have them?

24 A Yes, that should be enough.

25 MS. NEIMAN: Okay, so would you direct Dr. Napoli

1
2 within two weeks from today to produce those records
3 either in his office, by himself, by a messenger or
4 by name.

5 A Okay. May I have to whom I may send them.

6 Q My name which is on the bottom of the subpoena, and
7 the United States Court House, 40 Center Street, Foley
8 Square, same place you are in, Room 301A, which is my room
9 and it's on the bottom of the subpoena.

10 A Oh, it is there, fine.

11 MS. NEIMAN: Would you excuse Dr. Napoli.

12 THE FORELADY: You are excused.

13 (Witness excused.)

14 (Time noted: 3:00 o'clock, p.m.)
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COURT OF APPEALS
SECOND CIRCUITUNITED STATES OF AMERICA,
Appellee,

- against -

ANTHONY NAPOLI,
Defendant-Appellant.

Index No.

Affidavit of Personal Service

STATE OF NEW YORK, COUNTY OF

SS.:

I, Kevin E. Thomas, being duly sworn, depose and say that deponent is not a party to the action, is over 18 years of age and resides at 1515 Macombs Road, Bronx, N.Y. 10452,

That on the 15th day of July, 19 77 at One St. Andrews Plaza
New York, N.Y.

deponent served the annexed

Exhibit Volume

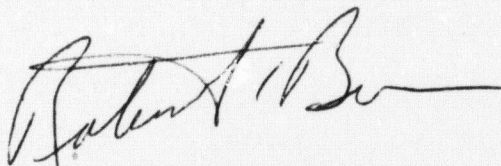
upon

U.S. Atty Southern Dist.

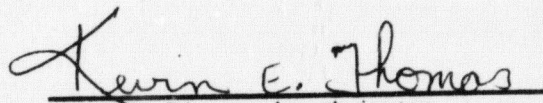
Robert Fiske Jr.

the in this action by delivering a true copy thereof to said individual personally. Deponent knew the person so served to be the person mentioned and described in said papers as the herein,

Sworn to before me, this 15th
day of July, 19 77



ROBERT T. BRIN
NOTARY U.S. C. State of New York
No. 31-0418950
Qualified in New York County
Commission Expires March 30, 1979



Print name beneath signature

KEVIN E. THOMAS

BEST COPY AVAILABLE